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PROPOSALS TO MODIFY MEDICARE'S PHYSICIAN PAYMENT SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

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PROPOSALS TO MODIFY MEDICARE'S PHYSICIAN PAYMENT SYSTEM

FRIDAY, APRIL 25, 1986

U.S. SENATE,
SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger, Heinz, Baucus, and Mitchell.

[The press release announcing the hearing, a background paper titled "Physician Reimbursement Under Medicare," and Senators Durenberger's and Mitchell's written statements follow:]

[Press Release, March 21, 1986]

FINANCE COMMITTEE SUBCOMMITTEE ON HEALTH TO EXAMINE PROPOSALS TO MODIFY MEDICARE'S PHYSICIAN PAYMENT SYSTEM

Proposals to modify the current physician payment system under Medicare will be examined at a Committee on Finance Subcommittee on Health hearing scheduled for April 25, 1986, Chairman Bob Packwood (R-Oregon) said today.

Senator Packwood said Senator David Durenberger (R-Minnesota), Chairman of the Subcommittee on Health, would preside at the April 25 hearing.

Senator Packwood said no fundamental change in Medicare's reimbursement methodology for physicians has occurred since 1972 and Congress should carefully examine all proposals to "fine tune" the current system.

The Administration's Budget for Fiscal Year 1987 includes several regulatory proposals to modify payments to physicians. In addition, it is expected that legislative proposals to modify physician payments will be forthcoming from Members of the Finance Committee prior to the April 25 hearing.

Chairman Packwood said the Subcommittee on Health expects to receive testimony from Administration officials, as well as representatives from provider and beneficiary groups.

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PHYSICIAN REIMBURSEMENT UNDER MEDICARE

Background Paper

Prepared for the Use of the Members of
The Committee on Finance

Jennifer O'Sullivan
James Reuter
Specialists in Social Legislation
Education and Public Welfare Division
April 22, 1986

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PHYSICIAN REIMBURSEMENT UNDER MEDICARE

I. OVERVIEW

Medicare's expenditures for physicians' services increased at an average annual rate of 20.6 percent over the 1979-1983 period. As an interim measure to control these escalating costs, Congress approved in 1984, a 15-month freeze on physicians' fees under the program. The freeze period was slated to end September 30, 1985. P.L. 99-107, as amended, extended the freeze period through March 14, 1986. On April 7, 1986, the President signed into law P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as COBRA). This measure extends the freeze until December 31, 1986 for "nonparticipating" physicians and lifts the freeze for "participating" physicians effective May 1, 1986. The freeze provisions are viewed, however, as a temporary means of stemming increases in program expenditures for physicians' services.

Medicare pays for physicians' services on the basis of Medicare-determined "reasonable charges." The reasonable charge is the lowest of:

(1) the physician's actual charge for the service;

(2) the physician's customary charge for the service; or

(3) the prevailing level of charges made for the service by all physicians in the same geographic area.

Prior to the freeze, customary and prevailing charge screens generally were updated annually, with increases in prevailing charges limited by an economic index that reflects general inflation and changes in physicians' office practice costs.

Medicare payments are made directly either to the doctor or the patient depending on whether the physician has accepted assignment for the claim. In the case of assigned claims, the beneficiary transfers his payment rights under Medicare to the physician. In return, the physician agrees to accept Medicare's reasonable charge as payment in full (except for the required deductible and copayments). If the physician does not accept assignment, Medicare payments are made to the beneficiary who, in turn, pays the physician. Beneficiaries are liable for required deductible and coinsurance amounts and, in the case of non-assigned claims, for any difference between Medicare's reasonable charge and the physician's actual charge.

The Deficit Reduction Act of 1984 (DEFRA) froze Medicare recognized customary and prevailing charges for all physicians' services provided during the 15-month period beginning July 1, 1984 at the levels in effect on June 30, 1984. DEFRA also established the participating physician and supplier program. Participating physicians or suppliers (such as clinical laboratories or durable medical equipment suppliers) are those who agree to accept assignment for all services provided to all Medicare patients during a 12-month period. The first such period began October 1, 1984. The primary incentive for physicians to participate was the ability to raise actual charges during the freeze period so that such increases could be reflected in the calculation of customary charges in subsequent years. Nonparticipating physicians could not raise their actual charges during the freeze period above the levels they charged during April-June 1984.

P.L. 99-107, as amended, extended the freeze through March 14, 1986. COBRA further extends the freeze through April 30, 1986 for all physicians and through the end of the year for nonparticipating physicians. During April 1986, physicians are being given the opportunity to change their participation status for the 8-month period beginning May 1, 1986. Future participation cycles, and updates in customary and prevailing charges, will occur on January 1 of each year beginning in 1987. Beginning January 1, 1987, nonparticipating physicians will be subject to the prevailing charge limits applied to participating physicians during the preceding participation period. There will be a permanent 1-year lag in prevailing charge levels applicable for nonparticipating versus participating physicians.

The Medicare fee-for-service payment system has undergone relatively few changes since the program's inception. It has been criticized by some because it allegedly permits distortions in payments and fails to provide adequate protection for the elderly against rising physicians' fees. These concerns are reflected in:

(1) imbalances in payments for individual services, and

(2) the unit of service for which payment is made.

With respect to payment imbalances, Medicare frequently recognizes a higher fee when the same service is performed by a specialist rather than by a general practitioner or when provided in a hospital rather than in an office setting. There is also a wide variation in recognized fees between various geographic regions. Further, physicians generally are paid substantially less for their primary care skills than for their technical skills. Finally, new procedures generally are priced at a high level and charges generally are not lowered over time even though increased experience and higher volume actually have reduced both the costs and time involved.

Use of the individual service as the unit for payment also has been the subject of criticism. While some surgeons are essentially paid a single comprehensive fee for an inpatient case, including both pre- and post-operative care, the majority of all physicians' payments are made for each unit of service. It has been argued that this reimbursement system encourages physicians to provide additional services (such as laboratory tests), order additional consultations, or perform additional surgeries. While these actions may not be outside the broad range of accepted medical practice, other less costly alternative treatment patterns may be equally, or in some cases more, appropriate. Another frequently cited problem with the current unit for payment is the phenomenon known as "unbundling," i.e., billing separately for services that previously had been consolidated into a larger service category and therefore payment unit; the total amount paid for such multiple individual services may exceed the amount which would have been paid if they had been grouped under a single category, i.e., "bundled."

It also has been suggested that existing coding policies are somewhat inflationary. Procedure codes for some high volume procedures such as office visits are not precisely defined; it may thus be possible to describe the same service by more than one code, giving the physician the option of selecting the code with a higher allowable charge (so-called code-creep).

Physicians' decisions about pricing and billing have a direct economic impact on beneficiaries both in terms of the required 20 percent copayment amounts and the amounts in excess of approved charges on unassigned claims.

For several years, both the Congress and the Administration have been exploring alternative approaches to containing escalating expenditures for physicians' services. Three long-term reform options which have been suggested are:

(1) fee schedules based on a relative value scale (RVS);

(2) predetermined comprehensive payments for physicians' services provided to hospital patients based on the patient's diagnosis (so-called physician DRGs); and

(3) capitation.

The first option for revising Medicare's reimbursement system would be to establish a uniform national fee schedule for all physicians' services. Fee schedules are set payment amounts for each service. The most frequently suggested method for establishing a fee schedule would be to utilize an RVS which weights each service in relation to other services. The RVS is then translated into a fee schedule (dollar amount) by use of a predetermined conversion factor or multiplier. The use of a national fee schedule has the following advantages:

(1) Wide payment fluctuations among physicians in payments for similar services would be removed, though certain area-wide adjustments for cost-of-living or cost-of-practice differentials might be permitted;

(2) Medicare payments to physicians would be known in advance; and

(3) Medicare would exercise control over the amount the program would pay for individual services.

The primary disadvantage of this approach is that it would not provide control over total expenditures since it retains the individual service as the payment unit. Thus, this approach could have less impact on controlling expenditures than other reform options such as capitation unless controls on intensity and volume were also incorporated in the new system.

The recently enacted COBRA requires the Secretary of the Department of Health and Human Services (DHHS) to develop, with the advice of the newly established Physician Payment Review Commission, an RVS and make recommendations to Congress by July 1, 1987 concerning its potential application to Medicare.

The second reform option which has been suggested is the use of predetermined comprehensive payments for physicians' services provided to hospital inpatients based on the patient's diagnosis. The "Social Security Amendments of 1983" (P.L. 98-21) established a prospective payment system (PPS) for inpatient hospital services based on diagnosis-related groups (DRGs). P.L. 98-21 also required the Department to study the advisability and feasibility of extending this approach to physicians' services. The report, due July 1, 1985, has not been transmitted to the Congress. It was expected that a physician DRG payment system for inpatient services would involve the establishment of a predetermined rate for each of the 468 DRGs used under the PPS system. However, there is some concern that the existing DRG classification system, which was designed to reflect hospital costs, may not adequately reflect differences in physician input costs. Another issue in designing a physician DRG payment system is determining to whom the payment should actually be made; payments could be made to the admitting physician, medical staff of the hospital or the hospital itself. One consideration in making this choice is the degree of financial risk that may be imposed on the various parties involved. This risk reflects the proportion of sicker patients treated and how widely the risk is spread.

A physician DRG payment system would give physicians (or physician groups) the incentive to practice more efficiently since they would be at risk for any costs in excess of the package price. This payment approach would directly address the problem of unbundling for services provided in the inpatient setting. It would also address the divergence of economic incentives that currently exist between hospitals and physicians. However, the concern has been expressed that if hospital and physician incentives are too closely aligned, the quality of patient care may be affected adversely.

While a physician DRG payment approach would limit expenditures for individual admissions, it might not control overall expenditures. For example, physicians could change their practice patterns such that:

(1) certain complex cases would be managed in two or more admissions instead of one; and

(2) some services related to the inpatient stay could be performed in outpatient settings either before or after the hospital stay and be billed for separately.

A third reform option is capitation. Under this type of system, Medicare would pay entities, such as health maintenance organizations or private insurers, a predetermined per person monthly fee or capitation payment. In return, the entities would be responsible for financing a specified set of benefits, including physicians' services. One advantage of this approach is that the organization would have a financial incentive to control costs. However, if the capitation payment is too low, the approach could lead to underutilization and a decline in the quality of care. Medicare currently pays risk-contracting health maintenance organizations and competitive medical plans on a capitated basis for benefits provided to a small proportion of the Medicare population who have voluntarily enrolled in these plans. It has been suggested that capitation payments could also be made to insurers who would provide benefits to all beneficiaries in a geographic region. However, there is little experience with this approach. A major issue in the design of a capitation system is how to determine the appropriate level of the capitation payments.

Regardless of the reform option chosen, the issues of physician assignment and physician participation would need to be examined. One approach would retain the current voluntary approach. Another would require physicians to accept Medicare's payment rate as the full payment (plus the required coinsurance).

In connection with its continuing interest in physician reimbursement issues, the Congress required the Department to prepare two reports for submission in July 1985. The first report, noted above, concerns the possible application of a DRG type payment system to physician services provided in the inpatient hospital setting. The second is to examine the impact of the freeze on the volume and mix of services provided.

The Congress also required the Office of Technology Assessment (OTA) to prepare a report on physician payments. This report was submitted in February 1986.

II. CURRENT PROGRAM

A. Medicare Coverage of Physicians' Services

Total Medicare outlays were $71.4 billion in FY85; of this amount, $48.7 billion were Part A outlays and $22.7 billion were Part B outlays. Of Part B outlays, 72 percent represented payments for physicians' services ($16.5 billion). Physicians' services covered by Medicare include those provided by doctors of medicine and osteopathy, whether furnished in an office, home, hospital or other institution. Also included under certain limited conditions are services of: dentists (when performing certain surgeries or treating oral infections), podiatrists (for certain non-routine foot care), optometrists (for services to patients who lack the natural lens of the eye), and chiropractors (for treatment involving manual manipulation of the spine, under specified conditions). Medicare payments accounted for 18 percent of the income of all physicians in 1982.

The Part B program generally pays 80 percent of the "reasonable charge" for covered services after the beneficiary has met the Part B annual deductible amount of $75. The beneficiary is liable for the 20 percent coinsurance charges, plus, for non-assigned claims, physicians' charges in excess of the Medicare-determined "reasonable charge."

Five specialties accounted for over half of Medicare physician spending in 1983. These were:

(1) internal medicine (20 percent of the total);
(2) ophthalmology (10 percent);
(3) general surgery (9 percent);
(4) radiology (8 percent); and
(5) general practice (6 percent).

Medical care (primarily physicians' visits) accounted for 37 percent of Medicare spending for physicians' services while surgery accounted for 34 percent in 1983. (The remaining 29 percent includes diagnostic laboratory and x-ray services, anesthesia services, and consultations). Sixty-two percent of spending is for services delivered in hospital inpatient settings while 29 percent is for services rendered in physicians' offices. (The remaining 9 percent includes services rendered in hospital outpatient departments and skilled nursing facilities).

For the aged, Medicare spending accounted for an estimated 57.8 percent of the per capita expenditures for physicians' services in 1984 ($502 out of total $868). Out-of-pocket spending by the aged accounted for $227 (26.1 percent); private insurance spending represented $117 (or 13.5 percent) and other government spending $22 (2.5 percent).

Medicare is administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (DHHS). The day-to-day functions of reviewing Part B claims and paying benefits are performed by entities known as "carriers." These are generally Blue Shield plans or commercial insurance companies.

B. "Reasonable Charges"

Medicare pays for physicians' services on the basis of "reasonable charges," sometimes referred to as "approved charges." A reasonable charge for a service (in the absence of unusual circumstances) cannot exceed:

-- the actual charge for the service;

-- the physician's customary charge for the service; and

-- the "prevailing charge" billed for similar services in the locality (set at a level no higher than is necessary to cover the 75th percentile of customary charges).

Carriers delineate localities for purposes of determining prevailing charges on the basis of their knowledge of local conditions. Localities are usually political or economic subdivisions of a State. There are 225 localities nationwide.

Prior to 1984, customary and prevailing charge screens (i.e., benchmark limits against which actual charges are compared) were updated every July 1. Since 1975, the annual update in the prevailing charge screens has been subject to a limitation. This limitation (expressed as a maximum allowable percentage increase) is tied to an economic index known as the Medicare Economic Index (MEI) that reflects changes in operating expenses of physicians and in earnings' levels.

Because DEFRA froze physicians' fees through September 30, 1985, the annual increases in the customary and prevailing charge screens slated for July 1, 1984, did not occur. Subsequent updates were slated to occur October 1 of future years beginning in 1985. However, subsequent legislation postponed the update otherwise slated to occur on October 1, 1985. Under COBRA, the next update will occur on May 1, 1986 for participating physicians only. Future updates for all physicians will occur on January 1 of each year beginning in 1987. There will be a permanent 1-year lag in prevailing charges applicable for nonparticipating physicians versus participating physicians.

C. Assignment and Participation

Medicare payments are made directly either to the doctor or to the patient depending upon whether or not the physician has accepted assignment for the claim. In the case of assigned claims, the beneficiary transfers his right to the Medicare payment to the physician. In return, the physician agrees to accept Medicare's reasonable charge determination as payment in full for covered services. The physician bills the program directly and is paid an amount equal to 80 percent of Medicare's reasonable or approved charge (less any deductible, where applicable). The patient is liable for the 20 percent coinsurance. The physician may not charge the beneficiary (nor can he collect from another party such as a private insurer) more than the applicable deductible and coinsurance amounts. When a physician accepts assignment, the beneficiary is therefore protected against having to pay any difference between Medicare's reasonable charge and the physician's actual charge.

In the case of non-assigned claims, payment is made by Medicare directly to the beneficiary on the basis of an itemized bill paid or unpaid. The beneficiary is responsible for paying the physician's bill. In addition to the deductible and coinsurance amounts, the beneficiary is liable for any difference between the physician's actual charge and Medicare's reasonable charge.

A physician (except a "participating physician") may accept or refuse requests for assignment on a bill-by-bill basis, from different patients at different times, or from the same patient at different times. However, he is precluded from "fragmenting" bills for the purpose of circumventing reasonable charge limitations. He must either accept or reject assignment for all of the services performed on a single occasion. Additionally, when a physician treats a patient who is also eligible for Medicaid, the physician essentially is required to accept assignment. Total reimbursement for services provided to these dual eligibles is equivalent to the Medicare-determined reasonable charge with Medicaid picking up the required deductible and coinsurance amounts.

The law specifies that a physician who knowingly, willfully, and repeatedly violates his assignment agreement is guilty of a misdemeanor. The penalty for conviction is a maximum $2,000 fine, up to 6 months' imprisonment, or both.

In calendar year 1983, approximately 56 percent of claims were paid on an assignment basis. In 1984, the figure rose to 59 percent. By 1985, the figure was 69 percent. This recent increase primarily was attributable to two factors--the beginning of the participating physicians program on October 1, 1984, and the requirement that, effective July 1, 1984, claims for independent laboratory services be assigned.

A physician may become a "participating physician." A participating physician is one who voluntarily enters into an agreement with the Secretary to accept assignment for all services provided to all Medicare patients for a future specified period, generally 12 months. The first such period began Oct. 1, 1984. The law requires physicians to sign up prior to the start of the participation period. After that time, only new physicians in an area or newly licensed physicians may enter into a participation agreement until the beginning of the next designated time period. A nonparticipating physician is a physician who has not signed a voluntary participation agreement. A nonparticipating physician may accept assignment on a case-by-case basis.

The law includes a number of incentives to encourage physicians to become participating physicians. During the freeze period the primary incentive for physicians to participate has been the ability to increase their billed charges. While increases in billed charges do not raise Medicare payments during the freeze period, these charges will be reflected in the calculation of future customary charge screen updates. The freeze is lifted for participating physicians on May 1, 1986; however, nonparticipating physicians are subject to the freeze through December 31, 1986. During the entire freeze period, nonparticipating physicians may not raise their actual charges above the levels charged during April - June 1984. Further, beginning January 1987 there will be a permanent 1-year lag in the prevailing charges applicable for nonparticipating versus participating physicians.

In addition to the payment provisions, the law includes additional incentives to become participating physicians. These include the publication of directories identifying participating physicians, and the maintenance by carriers of toll-free telephone lines to provide beneficiaries with names of participating physicians. Further, beginning on October 1, 1986, all Explanation of Medicare Benefits (EOMB) notices sent to Medicare beneficiaries on unassigned claims must include a reminder of the participating physician and supplier program.

HCFA reports that for the participation period beginning October 1, 1985, 27.9 percent of physicians billing Medicare are participating, 32.2 percent of limited license practitioners (i.e., chiropractors, dentists, podiatrists) are participating, and 23.0 percent of Medicare suppliers are participating.

D. P.L. 99-272, Consolidated Omnibus Budget Reconciliation Act of 1985

On April 7, 1986, the President signed into law P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as COBRA). As noted, this legislation makes several significant modifications to the Medicare physician payment provisions.

Under COBRA, the existing payment provisions have been extended through 1986. In April 1986, physicians are given an opportunity to change their participation status for the 8-month period beginning May 1, 1986. Future update and participation cycles will begin on January 1 of each year beginning in 1987.

Physicians covered under participation agreements on May 1, 1986 will receive updates in their customary and prevailing charges. Physicians who participated in FY85 but are not participating for the period beginning May 1, 1986 will have their customary charges updated. For physicians participating during neither period, the existing freeze on customary and prevailing charges will be extended through December 31, 1986. The freeze on actual charges will be extended for all nonparticipating physicians for the same period.

The customary and prevailing charge screen updates applied on May 1, 1986 are those which would have occurred on October 1, 1985 except for postponements provided for under temporary extension legislation. To compensate participating physicians for the delay, the Medicare economic index will be increased by one percentage point increase. This increase will not be built permanently into the prevailing charge levels.

Beginning January 1, 1987, nonparticipating physicians will be subject to the prevailing charge limits applied to participating physicians during the preceding participation period. The law requires publication of directories (rather than a single directory, as previously required) identifying participating physicians. In addition, the Explanation of Medicare Benefits (EOMB) notices sent to beneficiaries is required, for nonassigned claims, to include a reminder of the participating physician and supplier program.

COBRA also provides for the establishment of an independent Physician Payment Review Commission. The mission and ongoing duties are to make recommendations regarding Medicare physician payments. The law also requires the Secretary, with the advice of the Commission, to develop a relative value scale for physician payments. The Secretary is required to complete the development of the RVS and report to Congress on its development by July 1, 1987. The report is to include recommendations concerning its potential application to Medicare on or after January 1, 1988.

COBRA also includes the following additional provisions relating to payment for physicians' services:

— Current law permits the Secretary certain flexibility in determining reasonable charges. Regulations allow the use of "other factors that may be found necessary and appropriate with respect to a specific item or service . . . in judging whether the charge is inherently reasonable." COBRA requires the Secretary to promulgate regulations which specify explicitly the criteria of "inherent reasonableness."

- COBRA makes technical corrections with respect to the calculation of customary charges for certain former hospital-compensated physicians.

- COBRA requires the Secretary to provide for separate payment amount determinations for cataract eyeglasses and cataract contact lenses and for the professional services related to them. The Secretary is to apply inherent reasonableness guidelines in determining the reasonableness of charges for such eyeglasses and lenses.

- COBRA denies Medicare payment for assistants-at-surgery in a cataract operation unless prior approval is obtained from the peer review organization (PRO) or Medicare carrier. Such assistants can not bill Medicare or the beneficiary for services which do not receive prior approval; not can the primary physician bill for such services. COBRA further requires the Secretary to report to Congress by January 1, 1987, recommendations and guidelines regarding other surgical procedures for which an assistant at surgery is not generally medically necessary.

E. P.L. 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985

P.L. 99-177, the "Balanced Budget and Emergency Deficit Control Act of 1985" (known as Gramm-Rudman-Hollings) established an automatic budget reduction procedure for FY86 - FY91 which provides for reductions in Federal programs if the budget deficit exceeds specified amounts in those years. If the deficit reduction process is triggered, the Medicare reductions are to be achieved by reducing payment amounts for services by a maximum of 1 percent in FY86 and by a maximum of 2 percent in subsequent years. These are reductions from amounts which would otherwise be paid under existing law and regulations. The law further specifies that on assigned claims, beneficiary liability may not be increased to compensate for the reduced payment amounts. However, on unassigned claims, beneficiaries are still liable for the difference between the billed amount and the reduced Medicare payment amount.

The sequestration process was triggered in FY86. The 1 percent reduction in Medicare payments for FY86 was effective March 1, 1986.

III. CURRENT SYSTEM ISSUES

Part B is primarily financed through Federal general revenues (approximately 75 percent of Part B expenditures). Enrollee premiums finance less than 25 percent of expenditures. The rapid cost increases and the resulting impact on the Federal budget are causing increasing concern. Since approximately three-quarters of Part B outlays are for physicians' services, the primary focus has been on ways to curb these expenditures. Initially, consideration was given to refining the existing reimbursement system. However, more recently attention has turned to consideration of alternative payment methodologies.

A. Prices for Individual Services

As noted, Medicare pays for individual services on the basis of "reasonable" charges. Reasonable charges cannot exceed the physician's customary charge or the prevailing charge for the service in the locality. The prevailing charge was originally set at the level necessary to fully cover at least the 75th percentile of customary charges. However, annual increases in recognized prevailing charge levels are subject to the economic index limitation (which is expressed as an allowable percentage increase). Physicians' fees generally have increased at a faster rate than the economic index. Between 1973 and 1984, the economic index increased by 106 percent while physician fees for services to all patients, as measured by the physicians' services component of the Consumer Price Index (CPI), increased 157 percent. Thus, each year an increasing percentage of physicians' customary charges are likely to exceed the index-adjusted prevailing charge limit. In these cases, the limit determines the approved payment amount. Estimates vary on the percentage of claims which are subject to the economic index-adjusted prevailing charge screen; it is generally believed that at least one-half of charges are subject to this limit.

The index-adjusted prevailing charge screens are serving as de facto fee schedules in many localities. Fee schedules are set payment amounts for each service. (For example, if the fee schedule amount were $20 for an initial brief office visit, this is the amount that would be paid for the visit regardless of the physician's charge.)

These de facto fee schedules, which vary considerably throughout the country, reflect and lock into place historical imbalances in charging patterns. Many feel that these imbalances have encouraged physicians to locate in high fee screen areas, to choose specialty over primary care practice, to treat patients in hospitals rather than outpatient settings and to perform surgical rather than than medical procedures. Some of the major problems which have been cited follow:

1. General Practitioner/Specialist Differential. Considerable variation exists in Medicare-determined reasonable charges for services performed by physicians in general practice versus reasonable charges for similar services performed by specialists. For example, the prevailing charge for a routine follow-up office visit may be $25 for a general practitioner and $30 for a specialist. In the 1984 fee screen year (i.e., July 1, 1983, through June 30, 1984), Medicare carriers recognized specialty reimbursement differentials in all areas of the country except for Florida, the area of Kansas served by Blue Shield of Kansas, North Dakota, South Dakota and the area of New York served by Blue Shield of Western New York.

The specialist/generalist differential recognized by Medicare and many private insurers was originally intended to reflect the fact that specialists often charge more because they provide a different type or higher degree of service. It has also been argued that specialists deserve higher fees in order to compensate them for the additional years of training they must receive in order to become a "board-certified" specialist. However, it has been noted that not all doctors paid as specialists under Medicare are board-certified.

While some believe that specialists may deserve higher fees when practicing within their specialty, many specialists also provide a significant amount of primary care. The fee differentials mean that Medicare is paying significantly more for what many feel are comparable services. For example, in fee screen year 1984, the mean prevailing charge for specialists was 16 percent higher than that for generalists for a "brief follow-up hosptial visit" and 24 percent higher for a "brief follow-up office visit."

Neither Medicare nor the medical community generally have established a single uniform definition for the term specialist. A report by the General Accounting Office (GAO/HRD-84-94, Sept. 27, 1984) reviewed how carriers establish prevailing rate structures and identified several problem areas. It stated that HCFA had given little guidance to the carriers in determining whether specialty differentials in fees were warranted for particular procedures, and that in turn, the carriers had conducted little or no analyses of this issue. The report cited wide differences in the way carriers recognize physician specialties in establishing prevailing charges. Some carriers did not recognize any specialties and had only one prevailing charge for a particular procedure. Others developed prevailing charges for each specialty individually. Others combined numerous specialties into several prevailing charge groups. The report noted that the use of more than one prevailing charge could lead to significant variations among physician specialties. For example, the prevailing charge for a "consultation requiring a comprehensive history" in an urban area of Massachusetts ranged from $40.00 for a general practitioner to $89.50 for a cardiologist or pulmonary disease specialist.

The GAO report also examined the practice of "self-designation" -- i.e., a physician classifying himself as specialist without being board-certified (i.e., certified by the specialty organization as having met certain training and competency requirements). In a review of three carriers, it was noted that approximately one-half of the physicians who self-designated a specialty were not board-certified in that specialty and about one-fourth of the physicians who designated themselves as subspecialists in internal medicine were not even board-certified in internal medicine.

2. Geographic Variations. Significant variations in Medicare-determined reasonable charges exist by geographic area. Differences occur between urban and rural areas, among the States and between various regions. For example, an analysis of fee screen year 1984 data showed that for a brief follow-up hospital visit (one of the most frequently billed services) performed by a physician in general practice, the prevailing charge ranged from $10.30 in rural Mississippi and two counties in Texas to $30.90 in New York City. [In Dade County, Florida, which utilizes a combined locality designation for physicians in general practice and specialists, the rate was $41.60]. In part, these geographic variations in fees reflect differences in the cost of doing business, such as differences in the cost of office space, salaries of support personnel, and malpractice insurance. Also, since physicians generally can not charge Medicare patients more than they charge their private pay patients for the same service, these differences in charges reflect variations in private sector charges. However, some have expressed concern that the magnitude of these variations encourages physicians to locate in high-fee areas, such as large cities, while reducing the availability of medical care in low-fee areas, areas, such as rural communities.

3. Failure of Prices to Fall as Practice Patterns Change. Physicians' charges for new procedures generally are set at a high level reflecting the fact that new procedures initially may require special skills and a substantial amount of a physician's time. However, the charge accepted for a new procedure becomes the base for future increases. Physicians generally do not lower their charges even though increased experience, higher volume, and technological changes actually have lowered the costs and time required to provide the service. An example frequently cited of a failure of charging patterns to reflect changes in practice patterns is that of coronary artery bypass surgery which is now a frequently performed procedure (50,000 under Medicare in 1982) but one whose charges have remained relatively high.

Some analysts have suggested that it might be appropriate to lower or modify the calculation of the reasonable charges for certain procedures. However, limited data exists on which procedures should be targeted and what charge levels would be appropriate.

4. Variations by Place of Performance. Physicians' services provided in an inpatient hospital setting are generally associated with higher reimbursement levels. For example, in fee screen year 1984, the mean prevailing charge for a "brief follow-up visit performed by a general practitioner was 21 percent higher in a hospital than in an office. For the same service performed by a specialist, the mean prevailing charge was 12 percent higher in a hospital than in an office. While hospitalized patients may require more intensive care, the physician does not bear the associated office costs such as overhead. Similarly, the cost to a physician of providing a service in a hospital outpatient department is lower than the cost of providing the identical service in his private office. The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) authorized the Secretary to limit the reasonable charge for services furnished

in a hospital outpatient department to a percentage of the prevailing charge for similar services furnished in an office. The implementing regulations set the limit at 60 percent.

5. Medical/Surgical ("Cognitive/Procedural") Differentials. Hospital-based procedures, particularly surgical procedures and those requiring expensive fixed equipment (such as certain diagnostic tests) generally are priced higher than office-based services. This differential is then reflected in Medicare's reasonable charges which raises the concern that the existing payment mechanism may encourage the performance of services, particularly surgical procedures, which not only command high physicians' charges but also consume large amounts of support and technical resources. A parallel concern is that the system may discourage physicians from spending time with patients to counsel or examine them. Thus, rather than spending the time needed to determine the minimum set of diagnotic tests that are medically necessary, the physician has a financial incentive to order additional tests. There are also some patients with problems that could be treated either medically (such as with drugs or other therapies) or surgically. While it is arguable that for some cases a medical approach is less risky and should be preferred, the current payment system encourages a surgical approach to treatment. The resulting payment imbalances are sometimes referred to as the "cognitive/procedural differential."

A few attempts have been made to determine the relative value of surgical procedures and medical office visits on the basis of resource costs as opposed to charges. A study by William Hsiao and William Stason 1/ focused on the pro-

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1/ Hsiao, William C. and Stason, William B. Toward Developing a Relative Value Scale for Medical and Surgical Services. In Health Care Financing Review, v. 1, n. 2. Fall 1979, p. 23-38.

fessional time expended and the complexity of the service. After standardizing for complexity between selected procedures, the study showed that physicians were paid as much as 4-5 times more per hour for hospital-based surgery than for office visits. A follow-up study 2/ using 1983 data showed that values of surgical procedures relative to office visits are, at a minimum 2 to 3 times higher when calculated on the basis of charges than when calculated from resource inputs.

B. Unit for Payment

A major concern about current Medicare reimbursement methodology is the use of an individual service as the unit for payment. For example, physicians can bill separately for an initial office visit, a follow-up office visit and for each individual lab test or x-ray procedure performed. While some surgeons essentially are paid a single comprehensive fee for an inpatient case including both pre- and post-operative care, the majority of all physician payments are made for each unit of service.

It has been argued that the reimbursement system encourages physicians to provide additional services (such as laboratory tests), order additional consultations, or perform additional surgeries. While these actions may not be outside the broad range of accepted medical practice, other less costly alternative treatment patterns may be equally, or in some cases, more appropriate. These treatment decisions also have an impact on total health expenditures. It is estimated that physicians' decisions directly influence 70 percent of all health spending.

2/ Stason, William B. Physician Reimbursement: The Role of Relative Value Scales. Testimony given to U.S. Congress. Senate. Committee on Finance, Subcommittee on Health, December 6, 1985.

Another frequently cited problem with the current unit for payment is the phenomenon known as "unbundling," i.e., billing separately for services that could be consolidated into a larger unit of service and therefore payment. For example, instead of charging a single comprehensive fee for a surgical case, a physician could submit separate charges for the surgery and for each of the pre- and post-operative office and hospital visits. It has been argued that the total amount the program pays for such multiple individual services frequently exceeds the amount which would have been paid if they had been grouped under an individual service category, i.e., "bundled." Unbundling is frequently cited as a significant contributor to increases in expenditures for physicians' services; however, the acutal dollar impact of unbundling has not been identified.

It also has been suggested that existing coding policies may be inflationary. Procedure codes for some high volume services such as office visits are not defined precisely. It therefore may be possible to describe the same service by a code with a higher allowable charge, for example a "brief visit" might become an "intermediate visit." This phenomenon has been labeled "code creep." There is also some question whether the increased number of individual procedure codes (rising from 2,000-2,500 in 1966 to over 6,000 today) may facilitate code creep.

The impact of these factors on Medicare expenditures is reflected in historical data on the components of increases in recognized charges per enrollee for physicians' services. The 1986 Annual Report of the Board of Trustees of the Supplementary Medical Insurance Trust Fund disaggregates increases in expenditures per enrollee for physician services into two components: price increases per unit of service and "net residual factors." The latter component includes increases in expenditures due to additional physician services per enrollee, greater use of specialists, use of more expensive techniques and technology and other factors. For the year ending June 30, 1984, about one-third of the total percentage increase in physician expenditures per enrollee was due to the "net residual factors" (3.2 percent out of a total of 11.6 percent). For the year ending September 30, 1985, when the freeze was in effect, these residual factors were expected to account for 84 percent of the total increase per enrollee (5.2 percent out of a total 6.2 percent).

Volume increases, unbundling, code creep and more extensive use of expensive services are thus important factors determining the level of overall expenditures for physicians' services. Several studies have shown that when limits are placed on allowable fees, increases in these residual factors may result. Experience during the Economic Stabilization Program (ESP) during the early 1970s is frequently cited as an illustration of this phenomenon. Analysis by the Urban Institute of the impact of the ESP in California showed that physicians countered attempts to control prices by increasing the volume of services provided and changing to a more complex service mix. In fact, gross Medicare incomes of these physicians actually increased more during the 2 years of price controls than in the year after the controls were lifted.

C. Patient Liability

Physicians' decisions about pricing and billing have a direct economic impact on patients. All Medicare patients are liable for the 20% coinsurance charges, though Medicaid or privately purchased "Medi-Gap" insurance may pay for some of these costs. In addition, when the physician does not accept assignment, beneficiaries are liable for amounts in excess of Medicare's approved or reasonable charge, an amount frequently not covered by "Medi-Gap" insurance policies.

The difference between the physician's billed charge and Medicare's reasonable charge is referred to as the "reasonable charge reduction." Reasonable charge reductions were made on 84.5 percent of unassigned claims in 1985. The amount of the reduction was 25.9 percent of billed charges or $33.37 per approved claim. Beneficiaries thus faced an effective coinsurance of 45.9 percent on unassigned claims. Aggregate reasonable charge reductions on unassigned claims in 1985 were $2.6 billion. Beneficiaries were liable for these reduction amounts. Comparable reasonable charge reductions were recorded for assigned claims though the beneficiaries were not liable for the reduction amounts.

The impact of reasonable charge reductions on unassigned claims is spread unevenly across the population. Nationwide, 59 percent of claims were paid on an assigned basis in 1984. The AMA Center for Health Policy Research 3/ reported that for physicians who treated some Medicare patients in 1984, 83.9 percent accepted assignment for at least some patients, an increase over the 75.6 percent recorded in 1982. In 1984, 32.1 percent of physicians always accepted assignment, and 16.1 percent never accepted assignment. The average percentage of patients assigned was 51.3 percent. Physician assignment behavior varied by region with the percentage of physicians that accepted assignment for one or more Medicare patients ranging from 78.2 percent in the North Central Region to 89.0 percent in the Northeast. Similarly, variations were recorded by specialty with the percentage accepting assignment for one or more patients ranging from 79.5 percent for general and family practitioners to 91 percent for internists.

3/ Medicare Assignment: Recent Trends and Participation Rates, Socioeconomic Monitoring System Report. American Medical Association, v. 4, n. 1, February 1985.

Until recently, all physicians have been able to accept or refuse assignment on a claim-by-claim basis. However, under the provisions of DEFRA and COBRA, physicians may become "participating physicians" and agree to accept assignment on all claims for the forthcoming year. As of this time, data is not available on how the implementation of the participating physician provision has affected beneficiary out-of-pocket payments. Individual beneficiary payments may go up, down or remain constant depending on whether the physician does or does not become a participating physician, and in the case of a non-participating physician, whether there is a change in the percentage of cases paid on an assigned basis.

IV. PRESIDENT'S FY87 BUDGET PROPOSALS

In testimony before this Committee in December 1985, the Administration indicated that it supported the capitation approach as the only reform option that "addresses both the price and utilization of services while still providing quality care." 4/ In the short term, however, consideration was being given to refinements in the current system.

On February 5, 1986, the President transmitted the proposed FY87 budget to the Congress. Included in the budget were the following five regulatory initiatives which would modify the existing payment mechanism for physicians:

- -- Medicare Economic Index (MEI). The Budget proposes to make a revision in the calculation of the MEI to correct what is described as a technical defect in the calculation of the index to account for the historical overstatement of housing costs. The index would be recomputed using the "rental equivalence" housing component of the CPI as a substitute for the current home ownership approach. The MEI would be recalculated beginning in the base year. The Administration estimated that in the absence of this change the MEI would increase by 2.82 percent in FY87. With the modification, the increase would be only 0.80 percent. This estimate assumed that the new fee screen year would begin October 1, 1986. COBRA delays the beginning of the fee screen year until January 1, 1987.

- -- Overpriced procedures. Payments for selected overpriced physicians' procedures would be reduced using the statutory authority to apply "inherent reasonableness" criteria in determining Medicare payments. These are procedures that are considered to be overpriced due to technological or productivity advances or geographic variations. The Department issued proposed rule-making on February 18, 1986. The proposed rule-making summarized the conditions under which the Secretary could use the "inherent reasonableness"

4/ Desmarais, Henry. Testimony given to U.S. Congress. Senate. Committee on Finance, Subcommittee on Health, December 6, 1985.

authority to establish either special methodologies or specific dollar limits when the fee paid under the existing methodology is inherently unreasonable. Under the proposed rule-making, the factors to be considered may include: price markup, utilization, differences in charges to non-Medicare patients or to other large-volume purchasers, cost, and charges in other localities. Using such conditions, the Secretary will issue notices in the Federal Register on specific procedures and set forth criteria, if any, under which the carrier may grant an exception. Examples of procedures which have been cited as potentially overpriced include cataract surgery, coronary artery bypass surgery, and pacemaker procedures.

-- Limit post-cataract surgery payments. The Budget contains two proposals in this area. The first, which was also included in COBRA would require carriers to use inherent reasonableness authority to set separate and more appropriate reasonable charge allowances for prosthetic lenses and the related professional services. Under the second proposal which was implemented by carrier manual instruction on January 1, 1986, all carriers have been required to implement a prepayment screen for replacement of cataract contact lenses.

-- Standby anesthesia. Payments to physicians who either provide standby anesthesia services or administer no anesthesia would be limited. A recent Inspector General study noted that the same payment methodology is used for anesthesia services regardless of whether an anesthesiologist administers general anesthesia or only stands by and monitors the general care of the patient while the surgeon performs local anesthesia.

-- Assistants at surgery. Payments would be limited for assistants at surgery where not considered medically necessary. On January 1, the Department implemented a pre-payment review for the medical necessity of all claims for assistants at surgery for cataract procedures. The Budget proposes extension of this review to other procedures effective October 1, 1986. COBRA, however, mandates prior authorization in order for payment to be made for assistants at surgery for cataract procedures.

V. REFORM OPTIONS

For several years, the Congress and the Administration have been exploring alternative approaches to contain escalating expenditures for physicians' services under Medicare. DEFRA included a 15-month freeze on physicians' fees and established the concept of "participating" physicians. The law attempted to protect beneficiaries from increased liability in connection with nonassigned claims by prohibiting nonparticipating physicians from raising their billed charges during the freeze period. COBRA extends the freeze for nonparticipating physicians through December 1986. However, the freeze provisions have been viewed as an interim approach until more permanent changes could be incorporated into the system.

Serious consideration of major reform options has been hampered by the following factors:

(1) major gaps in the data on what the program is currently paying for;

(2) physician opposition to a major alteration in the current fee-for-service/voluntary assignment system; and

(3) uncertainty concerning the actual impact of major reforms on both the program and beneficiaries.

However, in addition to rising fiscal concerns, changes in the health services marketplace as a whole and the Medicare program itself have generated increasing interest in reform options. The health services marketplace is increasingly subject to competitive pressures. This is reflected in increasing competition among physicians for patients in response to the developing oversupply of physicians (which is estimated by the Graduate Medical Education

National Advisory Committee at 63,000 in 1990); the increasing emphasis given by employers to obtaining lower cost insurance protection; the growth in the number of health maintenance organizations (HMOs); and the rapid rise of preferred provider organization (PPO) arrangements under which services are provided to subscribers at discounted prices.

At the same time that these changes are occurring in the health services marketplace, Medicare is implementing a major new prospective payment system (PPS) for hospitals which is replacing the earlier "reasonable cost" reimbursement system. The PPS system has altered the economic incentives for hospitals by encouraging them to keep patients hospitalized for as short a period as is medically necessary and to perform as few tests and procedures as are needed while the patient is hospitalized. The economic incentives for hospitals under PPS are thus significantly different from those for physicians who are providing and ordering services in the inpatient setting.

These changes have served to focus attention on ways of changing the existing economic incentives for physicians by changing the method of payment. Studies of a number of options and related issues are currently being conducted by HCFA, the Office of Technology Assessment, and other public and private entities.

The major alternatives which are being examined are:

(1) fee schedules (based on a relative value scale);
(2) physician DRGs; or
(3) capitation.

Reforms to the existing reimbursement system could be limited to services provided in an inpatient hospital setting (approximately 62 percent of physicians' expenditures) or could be applied to all physicians' services. Payment reforms either might be taken apart from or in concert with reforms in the current assignment system. Finally, reforms could be included as part of more extensive reforms in the Medicare program as a whole.

A. Fee Schedules

Fee schedules are set payment amounts for each service. For example, if the fee schedule amount is $20 for an initial office visit, this is the approved payment amount regardless of the physician's charge. As noted earlier, Medicare's limit on year-to-year increases in prevailing charges (i.e., the economic index limit) has led, in effect, to the use of de facto fee schedules in some localities. These de facto fee schedules are more often reflective of historical charging patterns rather that actual input costs.

One option for revising Medicare's reimbursement system would be to replace the current de facto fee schedules based on local charging patterns with a uniform national fee schedule. This would have the advantage of removing the wide payment fluctuations for similar services though certain area-wide adjustments for cost-of-living differentials might be permitted. Physicians would know in advance what Medicare's payment would be. This approach would not provide control over total expenditures since it retains the individual service as the payment unit.

Several methods have been suggested for developing a uniform fee schedule. The schedule could be based on relative values, existing charging patterns or negotiation with representatives of the physician community. These methods are not mutually exclusive. Elements of all three frequently are incorporated in discussions of a fee schedule based on a relative value scale (RVS).

An RVS is a method of valuing individual services in relationship to each other. An RVS is a table of weights that defines the relative values of services. Each service is assigned a weight. For example, an initial office visit could be assigned a weight of 2.5 and other services assigned higher or lower weights to indicate their "value" relative to an initial office visit. An RVS is not a fee schedule. It is translated into a fee schedule by use of a "conversion factor" or multiplier. For example, if the multiplier were $6, a service with a relative value of 2.5 would be priced at $15.00. There are a number of factors that might be considered in determining the appropriate level of the RVS multiplier. Since the multiplier determines how much will be paid, it could be used to control or limit aggregate expenditures for physician services.

RVSs are frequently discussed in terms of a weighting system that would reflect the physician's time, skill, and overhead costs required to provide each service. The goal would be to establish RVSs that yield fee schedules which eliminate or reduce the existing payment imbalances.

To date, RVSs generally have been developed on the basis of historical charging patterns. The best known RVS was developed by the California Medical Association (CMA). The California RVS (CRVS) was established in 1956 and subsequently revised several times. The most recent editions were based on charge data derived from claims files of third party payers in the State. No attempts were made to adjust the charge data to reflect alternative measures of relative "value," such as physician time or resource consumption. Several other professional societies also developed RVSs though many of these were based on the California model.

The use and development of RVSs was generally halted by the antitrust action of the Federal Trade Commission (FTC) in 1979. The FTC issued a consent notice which required the CMA to cease publishing, promulgating, or participating in the use of RVSs; further, previously issued schedules had to be withdrawn. In early 1985, the FTC issued an advisory letter to the American Society of Internal Medicine expressing the concern that RVSs developed by medical societies could be viewed as price fixing schemes. Nevertheless, a number of segments of organized medicine including the American Medical Association (AMA) and the American Society of Internal Medicine (ASIM) have expressed strong interest in developing or assisting in the development of an RVS for Medicare.

There are several studies which have been undertaken which attempt to determine the relative values of physician services. Hsiao and Stason 5/ of Harvard University developed a method for creating an RVS based on physician time, complexity of service and similar factors.

The Institute of Medicine is planning a 2-year study which would develop a set of principles for valuing physicians' services and then apply them to establish relative values for selected services.

A study by the Urban Institute 6/ explored various means of constructing RVSs. The study concluded that available information on such factors as time per procedure, complexity, severity, and resource costs is insufficient to allow timely development of a reliable cost-based RVS. The authors concluded that an initial RVS based on charge data was the preferable alternative. The report suggested that a "consensus development" process could serve a useful role in the review, evaluation, and adjustment of an RVS based on charges. Using this approach, an "expert panel" would modify the charge-based index values which appeared out of line based on subjective valuations of other factors such as production costs or complexity. The final report recommended the following three-step process:

(1) development of a relative "cost" scale based on modifications of a relative charge scale;

(2) conversion of the relative cost scale into a relative value scale based primarily on insurers' views of services

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5/ Hsiao and Stason, op. cit. and Stason, op. cit.

6/ Urban Institute. Final Report on Alternative Methods of Developing a Relative Value Scale of Physicians' Services, October 1984.

benefits, appropriateness for subscribers, risks, efficacy, and spillover implications for other services and costs; and

(3) conversion of the relative value scale into a fee schedule.

The Boston University Health Policy Institute 7/ used a "consensus panel" (i.e., expert group decision making) approach to utilize expert opinions to measure the relative complexity and severity of common surgical procedures. A developer of the consensus approach has, however, suggested that the process is cumbersome and time consuming. 8/

A key issue in the establishment of a fee schedule is the payment unit determination. If separately identifiable payments continued to be made for each individual service, the existing incentives for unbundling, code creep, and volume and complexity increases would remain. It may be possible to counter these incentives by defining frequently provided services more precisely and aggregating certain services into larger more comprehensive units. However, it is not clear what services should be included in these larger packages, particularly for ambulatory care.

A second set of issues relates to the initial level at which fees are established. Implementation of a uniform payment amount would mean that some persons would receive higher payments and some would receive lower payments than they would under the current system. If desired, this effect partially could be offset through a phase-in approach though this could result in higher overall expenditures.

7/ Egdahl, Richard H. and Manuel, Barry. A Consensus Approach to Determine the Relative Complexity-Severity of Frequently Performed Surgical Services. Surgery, Gynecology and Obstetrics, May 1985, v. 160, p. 403-406.

8/ Egdahl, Richard H. Testimony given to U.S. Congress. Senate. Committee on Finance, Subcommittee on Health, December 6, 1985.

It is expected that a fee schedule would be established with a certain target budget amount in mind. The conversion factor therefore would need to be calculated to reflect projections of volume, unbundling and other changes.

A third set of issues relates to the differentials, if any, which would be permitted by specialty, setting where the services are rendered, or geographic area. A nationwide fee schedule could increase fees to non-Medicare patients in areas where the Medicare fees would be higher than those being billed by local physicians. In areas where the Medicare fees would be far below the previously recognized prevailing levels, physicians would be less apt to accept assignment. The beneficiary then would be expected to pay fees significantly in excess of Medicare's reimbursement levels.

Theoretically, the fee schedule could be designed in such a way as to alter certain economic incentives in the current system. For example, the multiplier amount might be increased for medical visit procedures and lowered for surgical procedures.

The fee schedule amounts might be established on a competitive basis. Doctors could bid proposed conversion factors to Medicare with the program accepting a certain percentage of the bids. For those whose bids were not accepted, beneficiary cost-sharing might be higher. Additional incentives might be included for participating physicians.

Several recent developments have occurred with respect to development of an RVS. On January 15, 1986, the Department of Health and Human Services entered into a 30-month cooperative agreement with Harvard University for development of an RVS. William Hsiao is the principle investigator and the American Medical Association is a subcontractor. The RVS is to be based on resource costs taking into account time, complexity, opportunity costs, and overhead. During the development of the RVS it is also expected that procedures will be identified which are currently overpriced or underpriced.

As noted earlier, COBRA requires the Secretary, with the advice of a newly established Physician Payment Review Commission to develop a RVS and report to Congress on its development by July 1, 1987. The report is to include recommendations concerning its potential application to Medicare on or after January 1, 1988.

B. Physician DRGs

The Social Security Amendments of 1983 (P.L. 98-21) provided for the establishment of a prospective payment system (PPS) for inpatient hospital services based on diagnosis related groups (DRGs). The legislation also required the Secretary to report to Congress in 1985 on the advisability and feasibility of paying for physicians' services provided to hospital inpatients on the basis of a DRG-type classification system. The report was due July 1, 1985, but had not been forwarded to the Congress as of April 1, 1986.

It was expected that a physician DRG payment scheme for inpatient services would involve the establishment of a predetermined rate for each of the 468 DRGs used under the PPS system. The rate could be based on the average of allowable charges per admission during a base year. Rates which appeared out-of-line might be repriced, vis-a-vis rates for other services. Census division and urban/rural variations comparable to those under PPS might be included.

Physician DRG payments would provide a single predetermined payment for all physicians' services (whether provided by one or more physicians) rendered during the inpatient stay. The payment unit is generally thought of as starting with the hospital admission and ending with the hospital discharge. It would thus be consistent with the PPS unit of service which is the hospital stay. In some cases, e.g., certain surgical DRGs, the pricing package might be defined to include certain preadmission and/or post discharge services or time periods of services. This would counter incentives to unbundle some services; that is, to perform some services that are currently rendered during the inpatient stay either before or after the hospital stay such that they can be billed as separate services. However, for many DRGs, particularly nonsurgical DRGs, it would be difficult to define what preadmission and/or post discharge time period or services should be considered part of the inpatient episode for reimbursement purposes.

There is some concern that the existing DRG classification system which was designed to reflect hospital costs may not fully reflect differences in physician input costs. One approach to evaluating how well the DRG classification captures differences among patients in physician-related treatment costs is to compare what physician payments would be under a DRG approach to those made under the current system. If current payments are relatively consistent within a DRG, then the hospital-based DRG classification might be viewed as a reasonable means of classifying patients for physician payments. A recent study by Janet Mitchell 9/ showed that while there is relatively little variation in the cost of total physician services within many surgical DRGs, there were wide variations in such costs within medical DRGs. There are several possible explanations of this finding. One may be that the attending physician in a particular medical DRG may represent one of a number of specialties while the attending physician in a surgical DRG is generally representative of a single specialty. Another explanation may be the fact that the degree to which physician involvement is fixed or nondiscretionary is higher for surgical

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9/ Mitchell, Janet. Physician DRGs. New England Journal of Medicine, Vol. 313, n. 11, September 12, 1985, p. 670-675.

than for medical DRGs. The treatment for some medical cases simply may be less well defined than for surgical cases. For example, the treatment of a surgical case almost always involves both a surgeon and an anesthesiologist whereas the attending physician for a medical case may have many options including which diagnostic tests to order and whether or not to use other physicians as consultants on the case.

This study found that making payments on the basis of physician DRGs could thus result in inequitable losses for some physicians and windfall gains for others. Potential gains and losses were also found to be associated with physician specialty. General practitioners would gain on the average because they generally have lower fees than specialists admitting patients in the same DRG. Ophthalmologists generally would gain because they control their area of specialization while thoracic surgeons frequently would lose because they perform substantial amounts of less complex surgery for which there is a moderately large amount of fee competition from less highly trained specialists. Differences among winners and losers may also occur because of differences in practice styles (e.g., whether or not an assistant surgeon is used during cataract surgery) and the triaging of more seriously ill patients within a given DRG to certain specialties. As a result of the findings of this study, a number of persons have suggested that it might be appropriate, at least in the initial implementation stages, to limit a DRG payment system to inpatient surgical procedures.

One of the key issues in designing a physician DRG payment system is determining to whom the payment actually should be made. Payments could be made to the attending or admitting physician, the medical staff of the hospital or the hospital itself. One consideration in making this choice is the degree of financial risk that is imposed on the various parties involved. For example, an individual physician's caseload may consist of a higher proportion of sicker patients within a DRG category, requiring more intensive care than the average for that DRG. Placing an individual physician at risk potentially could encourage the provision of less care than was medically appropriate or the avoidance of more severe cases. Further, this approach would impose additional administrative burdens on physicians. If the payment were made to the attending physician, he would be responsible for obtaining requisite services from other physicians and paying them for services rendered. Problems could arise if physicians could not agree on how to subdivide the single payment.

Alternatively, physician DRG payments could be made to the medical staff of the hospital which would then be responsible for distributing the payments. It has been suggested that the distribution of payments among individual physicians could be based on their percentage of total billings. If total billings exceeded DRG payment amounts, each staff member would receive proportionately less, while if total billings were less than payments, each staff member would receive proportionately more. Thus, the physicians collectively would be at risk for either excessive utilization or excessive billings by individual members. This approach is similar to the method used by some health maintenance organizations (HMOs) to reimburse their member physicians. While placing additional burdens on hospital staffs, this approach would have the potential advantage of creating a risk pool of sufficient size to avoid unacceptable risks associated with increases in case severity (i.e., increase in the percentage of sicker patients requiring more care than average for a particular DRG).

Another approach would be to pay the hospital directly which would in turn distribute the funds. Payments could be made either as a separate physician DRG payment or as a combined amount for both physicians' and hospital services rendered during the inpatient stay. This approach places strong incentives on the hospital to contain expenditures. However, it would place the institution in the position of arbitrating payment disputes among physicians and, in the case of combined payments, among physicians and its own competing interests.

A physician DRG payment system would give physicians (or physician groups) the incentive to practice more efficiently since they would be at risk for any costs in excess of the package price. This payment approach would directly address the problem of unbundling for services provided in the inpatient setting. It also would address the divergence of economic incentives that currently exist between hospitals and physicians. Under PPS, hospitals have the incentive to hospitalize patients for as short a period as needed and to perform a minimum number of tests and treatments. Conversely, physicians have the incentive to keep patients in the hospital longer and to perform additional billable procedures. Implementation of a physician DRG system would align these incentives. However, the concern has been expressed that if hospital and physician incentives are too closely aligned, the quality of patient care may be affected adversely. The physician may no longer be as strong an advocate for needed medical services. Patient access to care may be affected if hospitals practice "skimming," i.e., admitting large numbers of patients who require less care than average for the DRG while referring elsewhere patients who require more care than average.

While a physician DRG payment approach would limit expenditures for individual admissions, it might not be effective in controlling overall expenditures. For example, physicians could change their practice patterns such that certain complex cases are managed in two admissions instead of one. It is also likely that many services would be transferred to outpatient settings and billed for separately.

The DRG payment limitations would not apply to services provided in outpatient settings -- roughly 35-40% of total physician expenditures. Many persons feel that the capability does not exist to extend the DRG approach beyond the hospital setting. DRGs for inpatients have been defined in terms of specific diagnoses which require comparable resources and are delimited by the hospital episode itself. Identification of payment units for purposes of outpatient services is more difficult.

However, a recent study 10/ explored the possibility of creating a DRG-like classification scheme for categorizing outpatient visits. This classification, known as Ambulatory Visit Groups (AVGs), seeks to create homogeneous types of patient visits based on the presenting problem, principal diagnosis, patient's age, visit status (old or new patient with old or new problem), and other factors. An analysis of 1976 data resulted in the formation of 154 AVGs. This research is being extended to explore the use of AVGs for paying physicians for ambulatory services.

Using AVGs as the payment unit for ambulatory care has many of the same advantages and disadvantages as the use of DRGs as the basis for paying hospitals for inpatient services. Services are bundled into larger units of payment, removing the incentives for over-utilization within the individual payment unit. As in the case of hospitals, the bundling could lead to under-utilization of medically necessary services. As with hospitals which can increase their revenues under PPS by increasing their admissions, physicians could increase their incomes under an AVG reimbursement system by increasing the number of

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10/ Fetter, Robert, et. al. Ambulatory Visit Groups: A Framework for Measuring Productivity in Ambulatory Care. Health Services Research, Vol. 19, No. 4, October 1984, p. 415-437.

visits per patient. Therefore, implementation of an AVG reimbursement system would probably have to include provisions for quality and utilization reviews.

C. Capitation

A third reform option is capitation. Under a capitation system, Medicare would pay an organization, (either a provider or insurance company), a set monthly fee, or capitation amount, for each Medicare beneficiary covered under the capitation contract. In return, the organization receiving the payment would be responsible for financing the care of the covered beneficiaries, including, but not limited to, that provided by physicians. A capitation payment is similar to an insurance premium. In essence, Medicare would purchase health insurance for its beneficiaries providing a specified scope of benefits. At the same time, the risks associated with providing these benefits would be transferred from Medicare to the "insuring" organization.

A capitation system incorporates financial incentives that differ from those of a fee-for-service system. Under a capitation system, the organization receiving the capitation payments bears the financial risks of overutilization and inefficiency. Thus, these entities have financial incentives to control utilization (through case-management and utilization review) and to develop cost-effective patterns of care. However, if these incentives are too strong (such as if the capitation amounts are too low), they could lead to underutilization and a decline in the overall quality of care.

Two general approaches to a capitation system have been suggested. The first is to make capitation payments to provider organizations, such as Health Maintenance Organzations (HMOs) or Competitive Medical Plans (CMPs). The second is to contract with entities, such as insurance companies, that would then serve as "at-risk" insurers for all beneficiaries residing within defined geographic areas.

Medicare currently pays some providers (risk-contracting HMOs and CMPs) on a capitation basis. Qualifying HMO/CMPs can enroll Medicare beneficiaries. For each enrolling member, the HMO/CMP is paid a monthly capitation amount equal to 95 percent of an amount known as the Adjusted Average Per Capita Cost (AAPCC). The AAPCC is an estimate of the expected cost to Medicare if the beneficiary had not enrolled in the HMO/CMP. The AAPCC levels take into account geographic differences in the cost of providing care, and certain characteristics of the enrolling beneficiaries (age, sex, whether institutionalized and whether eligible for Medicaid). Under current law, participating HMO/CMPs are financially responsible for all Medicare benefits, either both Part A and B benefits or Part B benefits only, depending on whether or not the enrollee is eligible for both Parts. Enrolling beneficiaries are liable for the cost of any non-emergency care they receive outside of the HMO/CMP without prior authorization from the plan.

It is predicted that the number of Medicare beneficiaries who are covered under these arrangements will grow substantially over the next few years. As of March 14, 1986, the Department had signed 118 risk contracts with organizations in 28 States covering over 500,000 enrollees. An additional 70 contracts, that would enable it to offer Medicare beneficiaries in nine other States an HMO/CMP option, were pending. Despite recent growth, beneficiaries covered under capitation contracts will still represent only a small fraction of the Medicare population. Even if this program's growth could be accelerated, it appears unlikely HMO/CMP enrollees would represent a majority of Medicare beneficiaries in the near future.

Under an alternative proposal, Medicare could contract with an entity, such as a carrier or insurer, that would serve as an at-risk insurer for all Medicare beneficiaries residing in a defined geographic area. This type of plan is sometimes referred to as a geographic capitation system. Medicare would essentially purchase a specified package of benefits for a specified capitation amount. The capitation amount could be based on the AAPCC as currently used for paying risk-contracting HMO/CMPs. Alternatively, the capitation amount could be determined by allowing potential carriers to bid or negotiate a set price. The entities would be responsible for determining provider payment amounts and payment units. These entities could also be allowed, and/or encouraged, to make use of HMOs and CMPs, where such organizations exist. To assure beneficiary access to care, the contracting organizations could be required to obtain physician participation agreements from a certain percentage of providers in the area.

There is relatively little experience with the concept of geographic capitation systems. The State of Texas has contracted on a capitation basis with a private insurer to provide acute care benefits under its Medicaid program. The State maintains control over eligibility and payment amounts while the insurer provides claims processing and utilization review services. The contract also provides for a sharing of risk between the State and the insurer.

Recently, Blue Cross/Blue Shield of Maryland proposed a variation of a geographic capitation system as a Medicare demonstration project. This proposal would offer Medicare beneficiaries in certain Maryland counties three options:

(1) continuation of existing Medicare program benefits;

(2) enrollment in an HMO; or

(3) enrollment in a Preferred Provider Organization (an organization of providers who continue to bill on a fee-for-service basis but who agree to bill discounted fees and to participate in the plan's utilization control programs).

A potential drawback of geographic capitation systems, and to a lesser extent certain types of HMOs, is that they do not necessarily change how physicians are paid. While Medicare's payments to the insuring organizations would be capitated, payments from the insurers to providers could retain the current mix of fee-for-service and capitation through established HMO/CMPs. The capitation limit would provide the insurers with incentives to implement effective utilization review programs and to develop new programs (such as PPOs) to encourage the use of low-cost providers. However, to the extent that physicians continued to be paid on a fee-for-service basis, many of the current problems (code-creep, unbundling, and incentives for over-utilization) could remain though the financial burden would not fall on Medicare.

A second problem with capitation systems is determining the appropriate level of the capitation payments. Medicare currently pays risk-contracting HMO/CMPs 95 percent of the AAPCC. Similar calculations could be made for other types of capitation systems. However, many persons feel that the AAPCC does not adequately reflect variations in the health status of enrolled populations. If capitated plans are permited to compete, such as two HMOs with similar service areas or a capitated plan with traditional Medicare, failure of the AAPCC to reflect enrollees' health status accurately could result in overpayments to some plans and underpayments to others. If all Medicare beneficiaries in a geographic area are assigned to a particular carrier or HMO (i.e. making the capitated system mandatory), there would be less concern regarding how accurately the AAPCC reflects variations in health status. This is due to the fact that, over a large geographically designed population, average utilization and costs, and thus average AAPCC payments, would be relatively stable and predictable. However, a mandatory capitation system would create other problems. For example, the current methodology for estimating the AAPCC uses claims data for non-capitated Medicare beneficiaries. With mandatory capitation, this source of data would disappear. Without current data, it could be difficult to update the AAPCC amounts after the capitation system was fully implemented.

D. Assignment/Participation Issues

Regardless of the reform option chosen, the issues related to assignment would need to be examined. Should physicians be required to accept Medicare's payment rate as the full payment (plus any required coinsurance) or should they be permitted to charge additional amounts? That is, should assignment be mandatory or optional? The issue of mandatory versus voluntary assignment has been the focus of debate for several years. The American Medical Association (AMA) is strongly opposed to mandatory assignment while a number of beneficiary groups have indicated their support.

Proponents of mandatory assignment note that under the current system, a number of beneficiaries have been faced with high and in some cases unanticipated out-of-pocket costs in connection with their doctors' bills. In FY85, beneficiaries effectively faced a coinsurance of 45.9 percent on unassigned claims; they were financially responsible for the 25.9 percent average reduction from billed charges in addition to the 20 percent statutory coinsurance amount. In many cases these out-of-pocket expenses were not anticipated because of beneficiary misunderstandings of the complex Medicare payment system. Even if they are anticipated, it may be difficult for many beneficiaries to budget for the reduction amounts associated with unassigned claims. Frequently, these amounts are not covered under health insurance policies supplemental to Medicare (so-called "Medi-Gap" policies).

Proponents of mandatory assignment suggest that the existing problems will be exacerbated if Medicare places additional limits on approved charges. They suggest that physicians may be less likely to accept assignment and that Medicare cost-savings will be transferred to beneficiaries in the form of increased out-of-pocket costs for unassigned claims. In addition, any incentives for efficiency that are incorporated in a new payment system could be largely offset unless assignment were mandated. It has been suggested that mandatory assignment would be particularly important under a physician DRG payment system. Otherwise, physicians could accept assignment for cases whose costs were less than the DRG rate and not accept assignment and bill the patient the additional amount when the costs were more.

Mandatory assignment would, in effect, limit overall payments for covered services provided to enrollees. Opponents of this approach contend that mandatory assignment would represent an unwarranted infringement into the private practice of medicine. It would interfere with the existing doctor-patient relationship by preventing physicians from freely entering into "contracts" with their patients. Advocates of the voluntary assignment approach state that since physicians currently have the option of accepting or rejecting assignment, Medicare beneficiaries are able to select from virtually the entire physician population. They argue that if assignment were mandated, a number of physicians might drop out of the program. Beneficiary access in certain geographic areas and/or to certain physician specialities would therefore be jeopardized. Patients who have established long-standing relationships with particular physicians might be forced to seek care elsewhere if they wished to receive program payments for services. Advocates of mandatory assignment have countered this argument by stating that the developing oversupply of physicians coupled with the importance of Medicare revenues in many physicians' practices make a significant access problem unlikely in most areas.

Opponents of mandatory assignment indicate that physicians as a group have been responsive to the financial concerns of their patients. Physicians are more willing to accept assignment in cases of financial hardship and are more likely to accept assignment as annual charges increase and as beneficiaries get older. They also note that the majority of beneficiaries have relatively modest annual liability in connection with physicians' claims.

VI. CONGRESSIONALLY MANDATED STUDIES

A number of entities, both governmental and private, are studying various aspects of physician reimbursement under Medicare.

The 97th Congress required the Department to prepare the following two studies which were due in 1985:

1. Physician DRG Study. P.L. 98-21, the Social Security Amendments of 1983, established the prospective payment system for hospitals based on DRGs. This legislation also required the Secretary to begin during FY84 the collection of data necessary to compute the amount of physician charges for services furnished to hospital inpatients for each DRG. The law required the Secretary to report to Congress in 1985 on the advisability and feasibility of paying for inpatient physicians' services on the basis of DRGs. P.L. 98-369 specified that the due date was July 1, 1985. This report had not been submitted as of April 1, 1986.

2. Study of Change in Volume and Mix of Services. P.L. 98-369 required the Secretary to monitor physicians' services to determine any change during the 15-month fee freeze in the per capita volume and mix of services provided to enrollees. The Secretary was required to report to the Congress by July 1985 on any changes that had occurred. The report was to include legislative recommendations for assuring that any restrictions in the growth of Part B costs which Congress intends to be borne by providers and physicians is not transferred to beneficiaries in the form of increased out-of-pocket costs, reduced services or reduced access to needed physicians' care. This report had not been submitted as of April 1, 1986.

The Department is conducting a series of studies on a broad range of physician reimbursement issues both in connection with the congressionally mandated reports as well as its ongoing interest in these issues. While some of these studies have been completed, the results have not yet been released by the

Department. It is anticipated that the findings will be included as part of the Congressionally-mandated reports.

P.L. 98-369 also required the Office of Technology Assessment (OTA) to report to Congress by Dec. 31, 1985, on findings and recommendations with respect to which Part B payment amounts and policies may be modified to:

> --eliminate inequities in the relative amounts paid to physicians by type of service, locality and specialty with attention to any inequities between cognitive services and medical procedures; and
>
> --increase incentives for physicians and suppliers to accept assignment.

The OTA report 12/ which was submitted in February 1986 examined four alternative Medicare payment policies: modifications to the current payment system, fee schedules, paying for packages of services, and capitation. The report noted that the effects of each strategy are difficult to predict, because of the uncertainty regarding physicians' behavior and the changing medical marketplace. The report suggests that the policy options that involve the least amount of change from the current payment methodology or that call for research and demonstrations could be implemented within 1 to 2 years. These policy options include: reducing the number of payment codes, instituting volume controls, and mandating assignment. Fee schedules based on historical charge data could also be implemented in the near future. However, other types of reforms, such as universal capitation, resource based relative values scales, and payments for some types of packages or bundles of services (such as physician DRGs) may require further research and demonstrations before they could be implemented.

12/ U.S. Conress, Office of Technology Assessment, Payment for Physician Services: Strategies for Medicare, OTA-H-294, Washington, D.C., February 1986.

In addition, the Congressional Research Service (CRS), through a contract with the Rand Corporation, is developing a microcomputer model that simulates the impact of changes in Medicare's physician payment policies on physicians' Medicare revenues. A draft of the final report of this contract is currently being reviewed. The initial development of the model by the Rand Corporation uses Medicare data from two States to simulate the effects on providers and beneficiaries of replacing the current reimbursement system with a fee schedule based on allowed charges. CRS will implement the model using a national Medicare data base.

VII. MEDICARE PHYSICIAN PAYMENT REFORM ACT OF 1986

The Medicare Physician Payment Reform Act of 1986 (to be introduced by Senators Dole, Durenberger, and Bentsen) would make the following additions to the statutory requirements governing physician payments under Medicare:

- Inherent Reasonableness Factors. COBRA required the Secretary to issue regulations describing factors to be used in determining those cases where the application of the standard payment process for a service allows payment that is not inherently reasonable. The bill would provide that the factors may include, but not be limited to instances when:
  - Prevailing charges in a particular locality are significantly in excess of or below those in comparable localities;
  - Medicare and Medicaid are the sole or primary sources of payment;
  - The marketplace is not truly competitive because of the limited number of physicians performing the service;
  - There have been increases in charges not explained by inflation;
  - Charges do not reflect changing technology, or reductions in acquisition or production costs; or
  - The prevailing charges in the locality are substantially higher than payments made by other purchasers.

  The bill would provide that regional differences in fees would be taken into account unless there is substantial economic justification (which must be explained in the rule-making process) for a uniform national fee or payment limit.

- Inherent Reasonableness Procedures. The bill would require the Secretary to utilize the rule-making process in any case where he proposes to establish a new reasonable charge, or a methodology for a new reasonable charge, based on inherent reasonableness determinations. The Secretary would be required to allow at least a 60-day public comment period on the proposed rule. The Physician Payment Review Commission established by COBRA would be required to comment on the proposed rule during the same time period. Final regulations would be required both to explain the factors and data the Secretary considered in making the final determination and to include and respond to the Commission's comments.

-- Development of Fee Schedule. COBRA requires the Secretary to develop an RVS and to make recommendations concerning its use. The proposed bill would require the Secretary both to develop an index for adjusting RVS payment levels to reflect justifiable geographic cost differences and to examine a possible adjustment to encourage physicians to locate in medically underserved areas. The Secretary would be required to develop an interim index for geographic cost differences prior to July 1, 1987; to collect data on costs of practice for purposes of refining the index by July 1, 1988; and to periodically update the index. The Commission would be required to make recommendations concerning the index. Further, the Secretary would be required to conduct a study of the advisability of redefining the current pay localities used by the carriers for defining prevailing charges.

-- HCFA Common Procedures Coding System. The bill would require the Secretary to simplify the payment methodology under this coding system (HCPCS) to ensure that the methodology minimizes the possibility of overstating the intensity or volume of services provided. Hospital providers of outpatient services would be required to use HCPCS for Part B services by July 1, 1987, and each carrier and intermediary would be required to use the coding system by January 1, 1988.

-- Medicare Economic Index (MEI). The bill would provide that the adjustment of the MEI, as proposed in the President's budget, would be made in two stages with one half of the adjustment becoming effective January 1, 1987, and the other half January 1, 1988. The Secretary would be required to utilize the rule-making process for proposed changes in the methodology, basis, or elements of the MEI.

STATEMENT OF SENATOR DAVE DURENBERGER
SUBCOMMITTEE ON HEALTH
MEDICARE PHYSICIAN PAYMENT REFORM
APRIL 24, 1986

Good morning. As all of us here today are well aware, the Medicare program is in the midst of fundamental reform. Prospective payment for hospitalization has removed the inflationary incentives of the old retrospective, cost-based reimbursement system; freedom to enroll in an HMO or prepaid health plan has led over 500,000 Medicare beneficiaries to opt out of the traditional Medicare program and into a plan of their choice.

Expansion of health care reform is both necessary and inevitable. The health care consumer -- and that includes the federal government as well as the individual consumer -- is demanding quality care at reasonable prices. At the same time, health care providers are demanding that reform be achieved openly and fairly.

Physician payment under Medicare is no exception to this process. Simply put, the physician payment system is a mess. As we heard at our heard at our hearing on December 6, 1985, it is confusing to beneficiaries and doctors alike, with unnecessary paperwork and uncertainty over reimbursement.

Passage of a comprehensive system for physician payment reform is still in the future, but we have begun to lay the groundwork. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, now termed "COBRA," physician payment under Medicare will undergo signficant changes. By establishing a Physician Payment Review Commission similar to PROPAC, and calling for the creation of a relative value scale and recommendations for the creation of a fee schedule, COBRA to some extent lays out a map for change.

In addition, we have the Administration's proposals, contained in the proposed budget for FY '87. If you look carefully at those provisions -- and I know that our witnesses today have done that -- you find that the short-term "refinements" the Administration is requesting in physician payment are perhaps a bit more than mere refinements after all.

I can't help but sympathize with those who call the Administration's proposals budget policy thinly disguised as health policy. If we're truly dedicated to deficit reduction, we'd better have the guts to do the job with our eyes open. The folks at OMB may be able to trick themselves into denying the damage done by indiscriminate cuts in health care programs, but we know better.

There are modifications that can be made to the Administration's proposals, and improvements to the changes under COBRA, to produce more responsible health care policy. Senator Dole, Senator Bentsen and I have developed a proposal which we believe will prevent HCFA from being "deputized" as the agent of OMB, and will lay out firmer groundwork for comprehensive reform of physician payment under Medicare.

Our bill, S. 2368, will take the Administration's authority to reduce fees and force that authority to respond to a process which would be laid out in the law. That process will guarantee that fee revisions are made on the basis of sound information which is available for public review and comment, and that fee revisions are made only after the comments of Medicare beneficiaries, physicians, and the new Physician Payment Review Commission are received and considered.

The bill will also guarantee that any fee schedule that is ultimately developed will take into consideration appropriate regional differences in fees and rising malpractice costs. And, it will be constructed in a way which does not work at cross-purposes with other federal policies that seek to modify the current geographic maldistribution of health personnel.

Finally, the bill will guarantee that any adjustments in the Medicare economic index are made reasonably over time and are not used as a tool for budget savings.

By making sure that administrative adjustments in fees are done in a fair and open way, we hope physicians will be satisfied with the process and we hope to avoid any "fallout" on beneficiaries. We also hope that administrative corrections of some of the problems inherent in the current "CPR" formula will mean that Medicare will no longer be a source of improper economic incentives affecting practice patterns, and that beneficiaries will find physicians recommending services and procedures based on nothing but their best medical judgment.

I welcome the opportunity today to hear our witnesses' views on whether these hopes are realistic. I am confident that their recommendations will prove valuable when we proceed to mark-up these provisions.

Statement of Senator George J. Mitchell
Subcommittee on Health
Hearing on Reform of Physician's Payments
under Medicare
April 25, 1985

Mr. Chairman, I want to thank you for convening this hearing today on an issue of great concern to Members of this Subcommittee and to Medicare beneficiaries across the nation.

I share the concern expressed by many others about the rising cost of physician services for Medicare beneficiaries. During the period from 1979-1983, Medicare's expenditures increased at an average annual rate of more than 20%. These rising costs are a burden to the Federal Government and to the millions of elderly beneficiaries who must pay increasing out-of-pocket costs for physician services.

I am particularly concerned about the inherent problems which exist in the current reimbursement mechanism for physicians under Medicare. I believe that the present system allows discrepency in reimbursement to physicians based upon their specialties of medicine, the geographic area in which they locate, and the type of facility in which they practice.

In my home State of Maine, community health clinics cannot recruit physicians to come to serve in rural areas. The Bucksport Regional Health Center, located in a beautiful town on the ocean, has been trying to recruit a physician for over two years without success.

I have met with family practioners from more remote parts of Maine whose total annual salary is less than $25,000, largely because of the low reimbursement rate from serving Medicare patients. Physicians who will serve in rural Maine for this kind of money are rare and are becoming more difficult to find as doctors begin their careers with tremendous debts accumulated from medical school.

I hope that the Committee will be able to work with the Department of Health and Human Services as well as medical organizations such as the AMA, to develop a workable alternative reimbursement methodology for physicians under the Medicare Program. We must carefully examine the problems that exist under the current system and find a viable plan to eliminate those discrepencies that are inherently unfair.

I look forward to hearing the testimony of the witnesses before us today, and to working with my colleagues in the Senate to improve the method of payment for physicians under the Medicare Program.

Senator **Durenberger**. Good morning. The hearing will come to order.

As all of us here today are well aware, the Medicare Program is in the midst of reform. Prospective payment for hospitalization has removed inflationary incentives of the old retrospective, cost-based reimbursement system; freedom to enroll in HMO's and other prepaid health plans is leading now almost a half-million Medicare beneficiaries to opt out of a traditional Medicare Program into a plan of their choice.

Expansion of health care reform to other areas is both necessary and inevitable. The health care consumer—and that includes the Government as well as the individual consumer—is demanding quality care at understandable and reasonable prices.

Looking over the summary statement of our friends from the American Association of Retired Persons, who represent the interests of a fairly substantial number of individual consumers, it sort of summarizes the concerns.

The Medicare current physician reimbursement system has caused overinflation and physician expenditure, has created disincentives for the use of cognitive and counseling services. They point out the reality that physicians' decisions control 70 percent of the total health care spending, and also the reality that in this reform era, in the prospective payment era, that tightening up on part A, shifts to outpatient care, and part B, a lot of service delivery, and thus, as they say, exacerbates part B spending problems and causes higher out-of-pocket costs for beneficiaries.

So I find it isn't only politicians and consumers that are interested in reform, and particularly in doing this reform openly and fairly; it is the physicians themselves, who recognize that they are and always have been the key to health care delivery, who would like to see this process be more open and more fair.

The physician payment system is a mess. As we heard at our first hearing on the subject on December 6, 1985, it is confusing to beneficiaries, and it is confusing to doctors. There is unnecessary paperwork and uncertainty prevails.

Passage of a comprehensive system for physician payment reform is in the future, but we are beginning to lay its groundwork.

Under the reconciliation bill called COBRA, physician payments under Medicare will undergo significant changes. By establishing a Physician Payment Review Commission similar to PROPAC and calling for the creation of a relative value scale and recommendations for the creation of a fee schedule, COBRA to some extent lays out a map for change.

In addition, we have this administration's proposals, contained in its budget for fiscal year 1987. If you look carefully at those provisions—and I know our witnesses today have done that—you find that the short-term refinements, as they are called, that the administration is requesting in physician payment are perhaps something more than refinements.

I can't help but sympathize with those who call the administration's proposals budget policy thinly disguised as health policy. If we are truly dedicated to deficit reduction, we had better have the guts to do the job with our eyes open. The folks at OMB may be able to trick themselves into denying the damage done by indiscriminate cuts in health care programs, but many of us know better.

There are modifications that can be made to the administration's proposals, and improvements to the changes under reconciliation. Bob Dole, Lloyd Bentsen, and I have developed a proposal which we believe will prevent HCFA from being deputized as an agent of OMB and will lay out firmer groundwork for comprehensive reform of physician payment under Medicare.

Our bill, S. 2368, will take the administration's authority to reduce fees and force that authority to respond to a process which would be laid out in the law. That process will guarantee that fee revisions are made on the basis of sound information which is available for public review and comment, and that fee revisions are made only after the comments of Medicare beneficiaries, physicians, and the new Physician Payment Review Commission have been received and considered.

Our bill will also guarantee that any fee schedule that is ultimately developed will take into consideration appropriate regional differences in fees and rising malpractice costs. And it will be constructed in a way which does not work at cross-purposes with other Federal policies that seek to modify the current geographic maldistribution of health personnel.

Finally, the bill will guarantee that any adjustments in the Medicare economic index are made reasonably over time and are not used as a tool simply for budget savings.

By making sure that the administrative adjustments in fees are done in a fair and open way, we hope physicians will be satisfied with the process, and we hope to avoid any fallout on Medicare beneficiaries.

We also hope that administrative corrections of some of the problems inherent in the current CPR formula will mean that Medicare will no longer be a source of improper economic incentives affecting practice patterns, and that beneficiaries will find physicians recommending services and procedures based on nothing but their best medical judgment.

I welcome the opportunity today to hear our witnesses' views on whether these hopes are realistic. I am confident that their recommendations will prove valuable when we proceed this year to mark-up these provisions.

Let us begin now with our first witness, Henry Desmarais, the Acting Administrator of HCFA.

I will say briefly what I said the other day at Dr. Bill Roper's hearing, that from the standpoint of the Finance Committee and its Health Subcommittee and our staff, we are indebted to Henry for the job that he has done over the last month in carrying on the transition between Carolyn Davis and Bill Roper. That is not easy to accomplish, particularly at this time in our policy lives; but I can't imagine that anybody could have done it better than Henry did.

So, we welcome you here today. We were looking for some good news from you. I understand we don't necessarily have some of the good news that we anticipated, so you may proceed with whatever you brought us.

STATEMENT OF HENRY R. DESMARAIS, M.D., ACTING DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Dr. Desmarais. Thank you, Mr. Chairman, for your kind comments.

It is a pleasure to be here again today to talk about physician reimbursement, and in particular to talk about the administration's proposals for fiscal year 1987, as well as to give you our preliminary views regarding the Medicare Physician Payment Reform Act of 1986, S. 2368, which was introduced yesterday.

As you know, Medicare reimbursement is built off of a system of customary, prevailing, and reasonable charges. It has been criticized by many as inflationary, confusing, and biased in a variety of fashions. All you need do is look at the 10-year period ending fiscal year 1983 and view average annual rates of growth of 20 percent per year to know that indeed it has been inflationary.

What I intend to do today is briefly summarize my prepared statement. However, I would ask that the full statement be entered into the record.

Senator Durenberger. They will be.

Dr. Desmarais. As a result of hospital prospective payment—the falling length of stay, the prospective payment incentives to provide only necessary testing, as well as the decreased rate of admissions in the Medicare Program, and there has been some progress in constraining the rate of physician growth.

In fiscal year 1985, the rate of growth in our payments was at 10.5 percent. However, outlays continue to rise rather dramatically and, for the most recent 12-month period for which we have good data, March 1985 to February 1986, the annual rate of growth in benefit outlays is 13.8 percent.

I would also point out that the physician component of the Consumer Price Index for fiscal year 1985 was 5.8 percent, versus the 3.7 percent for the overall Consumer Price Index.

As I noted in December, when I appeared before this committee, the administration views the ultimate physician reimbursement reform as capitation. We have already begun that process by entering into contracts with Health Maintenance Organizations and Competitive Medical Plans, and have also, in the President's budget, advanced again our voucher proposal which you introduced last year as S. 1985.

That voucher proposal would in fact build upon our experience with HMO's and CMP's, and expand the pool of entities that could qualify to receive capitated payments to include indemnity insurers. These insurers would offer a benefit package that is actuarially equivalent to the more traditional Medicare benefit package.

We certainly know that capitation will not be achieved overnight. In the interim, we have advanced a variety of refinements to the Reasonable Charge System. There were five principal refinements to the President's budget for fiscal year 1987, and I would like to take a few minutes to describe each of these.

The first deals with overpriced procedures, a problem that we would plan to approach via inherent reasonableness. In fact in February we proposed a regulation by which the Secretary would proceed through an orderly process to identify procedures that are overpriced and to propose a methodology to deal with them. These regulations would give us general authority, and we would intend, as we identified individual procedures, to come back with a proposed notice of how to deal with those situations. This is a process that certainly would allow for public comment.

As you know, the Comprehensive Omnibus Budget Reconciliation Act [COBRA], did deal with this issue, and we are now proceeding to study the implications of that provision with respect to the regulation we published.

Our second proposal was to reduce Medicare's payment for so-called standby anesthesia services, or what most anesthesiologists would prefer to note as physician-monitored anesthesia services.

Here, our goal is simple: it is to reimburse at a level commensurate with the degree of physician effort and involvement. Many have noted that the physician-monitored anesthesia services are less intense and require less physician involvement.

Our work here is built on an inspector general report which was recently finalized, and I would observe that a number of our Medicare contractors have already made this kind of change based on their own inherent reasonableness authority.

Our third proposal for fiscal year 1987 is to limit post-cataract surgery payments. There were two parts to this, the first of which has already been included in COBRA—that is, to use inherent reasonableness to set more appropriate reasonable charge allowances for prosthetic lenses and related professional services.

The second element of this proposal would require a review of medical necessity for the replacement of cataract lenses, and we have already implemented that through manual instructions to our contractors.

Our fourth proposal deals with assistants at surgery. Beginning January 1, we implemented a prepayment review of the medical necessity of assistants at surgery for cataract procedures. In the budget we propose to extend this approach to other procedures by October 1.

COBRA took a different approach, instead requiring prior authorizations for the use of assistance at surgery for cataract procedures. We are now working on implementation approaches for that particular provision.

The fifth proposal included in the President's budget would correct for an overstatement in the Medicare economic index by substituting a rental equivalence component rather than a housing component of the CPI. The Bureau of Labor Statistics has already made that change for CPI purposes. We had planned to do this October 1, but we are now examining the impact of COBRA on this provision.

First, the next update will not be October 1 but January 1. More importantly, however, a provision of COBRA seems to require that, if we made such a change, we would only be able to make the change for participating physicians, because the nonparticipating physicians are scheduled simply to inherit the prior year's prevailings of participants.

We are having the general counsel's office carefully examine whether in fact our preliminary views are accurate, but we are somewhat concerned that any kind of correction, whether for the MEI or any other way, might only be done for participating physicians rather than for all physicians, as would be more appropriate.

While I am discussing COBRA provisions, I would be remiss if I didn't take this opportunity to make you aware of one problem we expect to face early in May. One of the provisions of COBRA provided for an additional opportunity for physicians to indicate whether they were interested in becoming participating physicians. They have the entire month of April to do this. They must tell us by April 30, in writing, whether they wish to be participating physicians. Of course many of them may wait until that point, drop it in the mail and send it to our contractors. The problem is that for services delivered May 1 and beyond, the payment for those physicians depends a great deal on whether or not they are participating physicians.

So, there may be a 2-week period or so wherein we will not be able to pay claims for those services, while we await a determination of who is participating and who is not participating.

I would now like to take up the Medicare Physician Payment Reform Act of 1986, and give you our preliminary reaction.

Section 2 of that bill provides procedures for establishment of special limits on reasonable charges, and it would further define the entire notion of inherent reasonableness.

I would like to point out that the factors to be examined that are mentioned in this provision are rather consistent with those that we proposed in a regulation back in February. So, our view is, at this point, that the bill as drafted would really not add a great deal to the current practice, and we are concerned it could hamper our administration of the inherent reasonableness authority that we proposed in the February regulation.

Section 3 deals with the development of a fee schedule for physician services. As I noted in December, we view fee schedules as inherently regulatory in nature and therefore counter to the administration's policy. Nevertheless, COBRA did include a provision requiring the development of a relative value scale. We have entered into a cooperative agreement with Harvard University to develop such a relative value scale. I know one of the later witnesses is heavily involved in that effort with us.

The bill would add additional requirements to this ongoing effort. It would require the development of an index to reflect justifiable differences in cost of practice based on geographic location, without exacerbating the geographic maldistribution of physicians—and I am quoting from the bill's provision.

We are concerned, and we question the feasibility and advisability of attempting to define what is a justifiable difference, or developing a Federal index that could manipulate the physician distribution incentives.

I would like to pause for a minute and say that it is our view that many things contribute to the decisions physicians make in determining where they will locate. They may locate themselves near where they trained or where family members are, and it really is unclear whether the charge structure is an important determinant.

I would also observe something you are well aware of, and that is our recent experience with urban/rural payment differentials under prospective payment. It makes us wonder whether we really want to go forward and develop a Federal index as contemplated.

Section 4 of the bill requires the development and use of the HCFA common procedure coding system in hospital outpatient department billings. We welcome this provision; we believe it would be an important first step that would allow us to collect data in order to do some policymaking and to reform how Medicare pays for outpatient services.

The second part of this section would require us to simplify the payment methodology for physician services under the coding system. We believe that perhaps what is meant here is the collapsing of codes or rebundling of services for payment purposes. We would certainly want to do this in a budget-neutral way or at least in a fashion that would not increase total outlays. Also at this time we are unsure whether we could do those analyses in time as called for in the bill.

The final section deals with the Medicare economic index and would propose to phase in over 2 years an adjustment which the President's budget contemplates doing in a single year. Obviously, doing it that way would lower the level of expected savings and we feel would continue payments at an unjustified level.

In conclusion, we certainly agree with you that reform in the area of physician reimbursement is necessary. We believe that capitation, competition, and consumer choice are the direction to take. But in the interim, we need to refine the existing system.

We certainly look forward to working with you and this committee in that regard.

I will be happy to take your questions.

Senator DURENBERGER. Where is the Physician Payment Report that was mandated by the Social Security Act Amendments of 1983 and was due on July 1, 1985?

Dr. DESMARAIS. Mr. Chairman, the Physician Reimbursement Report to Congress is in the very final stages of review. [Laughter.]

Senator DURENBERGER. This is a recording. [Laughter.]

Dr. DESMARAIS. I would expect we would be able to transmit it next week. We had hoped to deliver it this morning, but that was not possible.

Senator DURENBERGER. Where is it right now, at this moment?

Dr. DESMARAIS. At this moment it is undergoing the final stages of review in the Executive Office of the President.

Senator DURENBERGER. In the Executive Office of the President? How long has it been at the Executive Office of the President?

Dr. DESMARAIS. The final version of the report has not been there very long, perhaps no more than a month; I think perhaps even less.

Senator DURENBERGER. No more than a what?

Dr. DESMARAIS. A month. [Laughter.]

Senator DURENBERGER. A President who was so interested in modifying the economic index in 1 year instead of 2 years can't get the report out of his office in a month? Well. Do you think next week?

Dr. DESMARAIS. Yes, sir.

Senator **Durenberger**. Why do you think next week? [Laughter.]

Dr. **Desmarais**. Because we are that close. As I said, we really had hoped to deliver it to this committee, because we know of your interest. I might say here that, God willing, my wife will deliver our second child next Thursday, and I would hope that this administration could deliver this report within the same timetable. [Laughter.]

As you know, the gestation period for the latter has been a lot longer. [Laughter.]

Senator **Heinz**. We also assume that the report wasn't as much fun to prepare. [Laughter.]

Senator **Durenberger**. Very good.

Senator **Baucus**. It is also the difference between human nature and mother nature, and mother nature is inexorable; human nature always rationalizes, too. That's the problem. [Laughter.]

Senator **Durenberger**. Right now, who is the Executive Office of the President?

Dr. **Desmarais**. Pardon me. What I am referring to is the Executive Office of Management and Budget. It certainly needs to review these kinds of reports.

Senator **Durenberger**. Right. Who is that right now? Who do you talk to on this subject over there?

Dr. **Desmarais**. Well, Mr. Miller and his staff.

Senator **Durenberger**. When you can't get Mr. Miller, who do you talk to?

Dr. **Desmarais**. Well, Debbie Steelman is the associate director with whom we deal.

Senator **Durenberger**. Very good.

Now, where is the study that was mandated by DEFRA and due in July 1981 regarding the possible changes in the volume of services provided under DEFRA's Participating Physician Program and the freeze on actual charges of nonparticipating physicians?

Dr. **Desmarais**. That is included in the report we just discussed as an appendix, and also included in the body of the report.

Senator **Durenberger**. So we are going to get twins, then, is that it? [Laughter.]

Let me ask you how you can characterize a fee schedule as regulatory in nature, particularly when you compare it with the current formula that we use?

Just for the sake of argument or discussion, I think of a fee schedule as procompetitive, and I think some of the people on our expert panels will back me up on this, because they do give the beneficiary a way to determine in advance what his or her cost sharing will be, depending on which doctor they see, which gives them some incentives for making decisions as between participating physicians. How do you react to that?

Dr. **Desmarais**. Well, I think one of the issues we examined was, no matter what we do in changing the way we pay physicians today, it will require a great deal of energy. The question is: "Do we want to invest a great deal of energy in going from the reasonable charge system, which many people view as almost being a fee schedule, to a fee schedule, rather than investing it in moving toward capitation in a variety of ways?"

Obviously, most people say a fee schedule would be maximum allowances, so there is still that uncertainty on the part of the beneficiary. And certainly it depends, as well, on whether the physician is participating or nonparticipating, or taking assignment or not taking assignment.

Senator **Durenberger.** But it we go, and when we go—let us put it that way. When we go to some kind of capitation for let's say a majority of Medicare beneficiaries—most people understand what capitation is; in effect it means that people buy private health plans rather than just going to see the doctor and running the paperwork on it, as we now do. Even under that circumstance, we, the insurer, or the elderly and disabled, will be interested in making sure that we are getting quality care from the highest quality physicians in the country.

It seems to me we have invested already a fair amount of effort into examining appropriate ways in which to reimburse physicians. I am just concerned for why you would say we can sort of forget about that part of the process, when what we are learning and maybe what we are adapting are the kinds of reimbursement systems that private health plans will also use in buying physician services.

Dr. **Desmarais.** Well, I guess we believe that in a capitation mode there will be a variety of reimbursement systems in place, as there are in any business undertaking, and that we really don't need a fee schedule to try to guide an entity, like an insurer, purchasing physician services.

Senator **Durenberger.** Henry, are there some better ways to do it than the road we seem to be heading down, with RVS and the variety of RVS modifications? Are there better things that you would recommend to the health plans of this world?

Dr. **Desmarais.** Well, HMO's certainly don't see the need, per se, to have a relative value scale in order to recompense their physicians. So I think there are a variety of ways of going, rather than simply using a fee schedule as a guide.

Senator **Durenberger.** I have to end here so that others can ask questions; but, having said that, the implication is that every physician in the country is going to be an employee or at least is going to be salaried in some way; or, the other implication that you need to clear up for us, from the standpoint of administration policy, there is an assumption here that everybody in the country is going to be in a capitation system, that at some point in the next few years there isn't going to be any need for us to hang on to the current reimbursement system. Is that your belief, that 100 percent of the beneficiaries will be buying competitive medical plans or some variance on that?

Dr. **Desmarais.** First I think we need to say—and I know this is important especially to Senator Baucus—that there are a variety of ways of defining what capitation is. We think there are capitation approaches which are very appropriate in the rural areas as well as in the more urban settings, where most of the HMO's are today. So I think there are just a variety of ways.

It is not clear to us that insurers and others are begging for some federally defined relative value scale that somehow will be used as a guide in their dealings with physicians.

Senator **Durenberger**. Well, I will continue to explore this and some lines of questions that deal with inherent reasonableness in fee reductions in the written questions that we will need for the record.

[The questions follow:]

[No response at press time.]

Senator **Durenberger**. John Heinz?

Senator **Heinz**. Mr. Chairman, thank you very much.

Dr. Desmarais, one of the things that would be enormously useful to I think all of us, but particularly the committee, in determining the extent to which capitation will have an effect on Medicare beneficiaries would be any data you have on the characteristics of the beneficiaries—and by data I mean such things as age, health status, utilization patterns—of those beneficiaries that have enrolled in the Medicare, HMO and CMP option program. Do you have any information on those beneficiaries?

Dr. **Desmarais**. We are just developing our data bases in the area of HMO's and competitive medical plans, and we do have a ways to go.

Certainly, one of the key questions will be "How much and what kind of data do we want to collect?" That is something we have had a contractor looking at and that we also have had work groups within the agency looking at. But certainly I don't think we could answer every question that you would want to pose this morning.

Senator **Heinz**. I have a different kind of paternal interest than you have at this time, as I was the author of the provision that made it possible for Medicare beneficiaries to enroll in HMO's and competitive medical plans.

At this point, just roughly, how many Medicare beneficiaries have elected to participate in those plans?

Dr. **Desmarais**. In the risk-based plans that you refer to, it is between 500,000 and 600,000 people. We have about 119 contracts signed.

Senator **Heinz**. Do you anticipate fairly rapid growth in that?

Dr. **Desmarais**. Our growth figures are somewhere in the neighborhood of 5 to 8 percent per month.

Senator **Heinz**. Per month?

Dr. **Desmarais**. Yes, sir.

Senator **Heinz**. Well, that would imply a 60-percent-plus increase per year? That is rather rapid. So, a year from now you would expect to have 1½ to 2 million people in the program?

Dr. **Desmarais**. We would hope so. Someone said that by 1990 we could have 25 percent of beneficiaries in some capitated program.

Senator **Heinz**. That is quite extraordinary. If everybody goes in the program, you won't need to capitate the rest of the SMI Program, will you?

Dr. **Desmarais**. Well, we are encouraged by the arrangements, and in fact that is why we are trying to propose additional entities that could qualify to get those kinds of capitated payments.

Senator **Heinz**. Now, you noted in referencing in your statement the Medicare Trustees Report a concern with the rate of growth in SMI expenditures. I think we all share your concerns. Are you in a position to tell us how much of that growth may be due to prospective payment? Have you done any analyses yet on the extent to which PPS has resulted in cost shifting to outpatient and physician services?

Dr. **Desmarais**. It is going to be very difficult ever to answer that question, simply because there is so much going on in the health care delivery system, including the movement to capitation and the impact it has, the changes in the prospective payment system, and so on. So, I think cause and effect are going to be very difficult to determine.

The rate of growth has always been very high on the part B side of the program.

Senator **Heinz**. Isn't it, though, important to try to make some at least educated guesses? Don't we know, almost a priori, that any prospective payment system such as the DRG's is going to force people out of hospital acute-care and outpatient settings into post-acute settings more rapidly and in greater number?

Dr. **Desmarais**. That is true, but some of the part B services we are talking about this morning are primarily the physician services. And really, those shouldn't be overwhelmingly affected, whether the care is on the inpatient versus the outpatient side; and in fact, with falling lengths of stay and so on, and the fact that in many instances the reasonable charge system pays more if you get the service on the inpatient side, it is not clear to me that in regard to physicians, services at least it should have a tendency to increase our payments.

Senator **Heinz**. I am going to run out of time here in a minute, but what kind of data base do you have that would allow either analysis or educated guesses?

Dr. **Desmarais**. Well, we are moving toward a more sophisticated data base for physician services. Up until fairly recently the data——

Senator **Heinz**. I am sorry, I am not sure I made my question clear. In terms of the cost shifting from part A to part B.

Dr. **Desmarais**. Well, the kind of data we will have to look at is how much we are spending in each of the different categories of coverage under Medicare, whether it is skilled nursing and so on, and what will be outlay data of various kinds and also claim data, service data, how many services, how many visits per beneficiary, those kinds of data.

Senator **Heinz**. And you will be able to relate that to specific cases in specific DRG categories, won't you?

Dr. **Desmarais**. I think we are years away from being able to do that kind of very sophisticated interrelationship.

Up until recently all of our data bases were rather segregated. We do have contractors working on helping us to integrate data bases so we can actually track beneficiaries as they go from one to the other and do the kind of more sophisticated and elegant work that you would like to see us do.

Senator **Heinz**. Mr. Chairman, I will not take any more of the committee's time. I would ask the Chair's permission and Dr. Desmarais' cooperation, if I might submit some additional questions for the record for his review. I would only note that when we held a series of hearings on the issue of what kinds of problems DRG's were creating, we had very significant testimony from the General

Accounting Office, Eleanor Chelimsky, who made the point that, in respect to HCFA's data collection and research efforts, we were simply not going to have either this year or 5 years from now the kind of data, the kind of information base, that would allow us to make informed public policy judgments.

It is my hope that Senator Durenberger and this committee can work with you to ensure that we do have that kind of data base. In this day and age of computers, it shouldn't be. beyond the imagination of man to achieve that, the types of research programs that will get the kind of information Senator Durenberqer and others, I think, want and believe we genuinely need to make good health policy judgments.

Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you, John. And those questions will be submitted.

You are going to respond to them, right?

Dr. DESMARAIS. Absolutely.

[The questions follow:]

[No response at press time.]

Senator DURENBERGER. Max Baucus?

Senator BAUCUS. Doctor, I understand that HCFA is proposing to change the Medicare economic index because it presently overstates certain costs, housing costs is one, as I understand it. And if that index is unchanged for fiscal 1987 there would be an inflation rate increase under that index of about 2.82 percent, but with the administration's proposals, the administration's adjustments, that would be adjusted downward to about a 0.8 percent increase.

As I further understand it, that is because the administration believes that there are these distortions in that index. Is my understanding basically correct?

Dr. DESMARAIS. Certainly, the historic distortions in what we are concerned about. The numbers that you cite certainly are not the final numbers; we would have to announce those numbers when the next Medicare economic index is published; but those numbers are consistent with the preliminary views of the actuaries.

Senator BAUCUS. If that is the case, and if the administration is concerned about those distortions, my question is, Why isn't the administration also concerned about another distortion? The first distortion concerns, in the administration's view, excessive costs the administration might have to pay. The second distortion I want you to address is the distortion that affects the Part A deductible for senior citizens with respect to hospital costs. You know, that is the distortion that is pushing up the part A deductible by about 43 percent over 2 years because lengths of stays are decreasing and because, under current law, a deductible is based upon the average per-day cost.

Why isn't the administration addressing that distortion? It sounds like the administration is concerned about one distortion, a distortion that hurts the administration's budget, but not concerned about a distortion that hurts the beneficiary's budget. Why the inconsistency?

Dr. DESMARAIS. Well, first let me repeat what you were told the other day by Dr. Roper at his confirmation hearing: We are examining that issue. Secretary Bowen has asked us to look at possible approaches to change here, and as you know, it is a statutory formula.

Of course, we can propose changes for your consideration, and the Congress can consider its own. We are looking at that issue. There are many things involved.

For example, under current law the hospital deductible also affects the size of cost-sharing on the skilled nursing facility side, and so on. There are a lot of ramifications.

We are looking at things such as Medigap policies. As you know, 65 percent of beneficiaries have Medigap policies, and I am wondering are they going up or are they staying level? Because length of stay is falling, we know that use of days in the hospital where cost-sharing is paid by Medigap has dropped very dramatically under prospective payment.

So, there may be some leveling off here and there, and I think we want to be sure we understand the magnitude the problems, who is impacted by them, and certainly what the financial impact would be.

As you know, the trustees report this year said that the financial outlook for the Hospital Insurance Trust Fund was not as good as last year, and it gave an insolvency date under intermediate assumptions of 1996.

Senator **Baucus**. Is the administration going to send a proposal that addresses that problem? Send to Congress a proposal which addresses this distortion?

Dr. **Desmarais**. I believe it would be premature for me to commit one way or the other. I can tell you that the Secretary does want to see what the options are, what the impact of those options would be on everyone, and then decisions will be made at that point.

Senator **Baucus**. When do you expect that decision will be made?

Dr. **Desmarais**. I believe that perhaps in a few weeks or so we would be able to present to the Secretary options for his consideration.

Senator **Baucus**. When do you think the Secretary will be in a position to decide?

Dr. **Desmarais**. Well, given the fact that he personally has asked for it and is personally interested, and is aware of your concern and the concern of many others, I think he will not wait very long to at least see what the options are. But there are many ramifications.

Senator **Baucus**. Yes; there are many ramifications. There are to senior citizens, too—very severe ramifications. And I hope that you keep those in mind.

In fact, in that same vein, Dr. Roper said here, before this committee on Tuesday, that in his personal view that distortion has been unfair to many elderly. He personally said it has been unfair to many elderly.

Dr. **Desmarais**. Yes; I was here when he said that.

Senator **Heinz**. Senator Baucus, if you would yield?

Senator **Baucus**. Sure.

Senator **Heinz**. I would just like to join you in your statement.

Senator **Baucus**. I thank the Senator.

Senator Heinz has been very active in this, as have others. Doctor, I am sure you know that.

Dr. **Desmarais**. Yes; I do.

Senator **Baucus**. And I urge you and the Secretary to act very quickly.

The second question concerns the administration's capitation approach to Medicare part B. Are elderly groups telling the administration that they want this new approach? Or are physicians telling the administration that they want this approach? Who likes this?

Dr. **Desmarais**. Well, certainly there are a variety of views on the subject.

Senator **Baucus**. Well, I am talking about the elderly. Let us talk about the elderly. What elderly groups are coming to the administration or that you have consulted with that say they like this approach?

Dr. **Desmarais**. Well, I have heard some very positive views expressed by the AARP and others.

Senator **Baucus**. The AARP likes the capitation approach?

Dr. **Desmarais**. Well, I don't want to be quoted or assumed to say that capitation is the only option that they are looking at. Of course, they have a variety of views with respect to physician reimbursement.

Senator **Baucus**. Is this their first choice?

Dr. **Desmarais**. Pardon me?

Senator **Baucus**. Is this approach their first choice?

Dr. **Desmarais**. I would prefer to let them speak for themselves on what their first choice is.

Senator **Baucus**. What about physicians? Is that their first choice?

Senator **Durenberger**. They are here, too, I think. [Laughter.]

Senator **Baucus**. I want to find out why the administration is pushing something that is not the first choice of the two primary groups.

Dr. **Desmarais**. The point is that we need reform. The Office of Technology Assessment's report perhaps says it best. It says:

> In an era of concern about containing medical expenditures, capitation payment has the advantage of having shown that it can reduce expenditures for care, apparently without compromising quality.
>
> Unlike fee-for-service payments, capitation payment gives recipients an incentive to use the most efficient number and mix of services to manage a patient's condition.
>
> Studies have consistently found that practices paid by capitation delivered care of at least as good and usually better quality than comparison groups.

I think the beneficiary inquires and the rate of growth in HMO/CMP enrollment are indications that somebody must be interested in this approach.

Senator **Baucus**. That is all very interesting, but that is not the question I asked. I didn't ask what OTA thinks; I was asking what elderly groups think about this and I was asking what physician groups think about it—not what OTA thinks. When they come up here, we will ask them, too.

Thank you.

Senator **Durenberger**. Thank you, gentlemen.

John, anything else?

Senator **Heinz**. One last question, Mr. Chairman, if I may.

It has to do with a subject in your testimony, Henry, about participating physicians. You mentioned that April 30 is the bewitching hour for final notification as to whether they are going to participate.

Dr. DESMARAIS. Yes.

Senator HEINZ. Last year the participation rate was approximately 28 percent. What reading do you have at this point as to whether you are ahead or behind last year's sign-up rate?

Dr. DESMARAIS. We don't have any estimates at this time. As you know, the bill itself was not received by the White House until the 1st day of April, it was not signed until the 7th day of April. Around that date, the letters went out to the 450,000 or so physicians. With mail time and so on, I think it is very early to say where we will end up.

One thing that I would say is that, despite the long physician fee freeze, and so on, that we have had, the assignment rate is still at 68 percent of claims, which is pretty astounding, much higher than historic figures.

Senator HEINZ. When do you imagine, all things taken into account, the directory of participating physicians will be printable and available?

Dr. DESMARAIS. By July 1.

Senator HEINZ. By July 1?

Dr. DESMARAIS. Yes, sir.

Senator HEINZ. Thank you.

Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you very much, Max.

Dr. DESMARAIS. Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you very much, Henry.

Next we will have a panel consisting of Dr. Paul B. Ginsburg, senior economist, the Rand Corp., Washington, DC, and Dr. William Hsiao, professor of economics and health policy, the School of Public Health, Harvard University in Boston, MA.

Gentlemen, we welcome you. Your full statements will be made part of the record, and you may proceed to summarize them in 5 minutes each, knowing that we have all read the statements and will continue to analyze them.

Paul?

[The prepared written statement of Dr. Desmarais follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

HENRY R. DESMARAIS, M.D.
ACTING ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH
SENATE FINANCE COMMITTEE

APRIL 25, 1986

SUMMARY OF STATEMENT OF HENRY R. DESMARAIS, M.D.
ACTING ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE SUBCOMMITTEE ON HEALTH, SENATE FINANCE COMMITTEE
APRIL 25, 1986

Although progress has been made on reducing the rate of growth in spending for Medicare physicians' services, in the 1986 Trustees' Report, the Board noted "with concern the rapid growth in the costs of the program" and recommended "that Congress continue to work to curtail the rapid growth in the Supplementary Medical Insurance program."

The Administration is committed to capitation as the best means to achieve physician payment reform. In order to advance this policy, the FY 1987 budget proposes through the voucher program to expand the capitation options available to our beneficiaries. The budget also proposes steps that can be taken in the near term to address some of the problems of CPR and to maintain constraint on spending for physicians' services. These include:

o Reducing Payments for Overpriced Procedures
o Reducing Payments for Standby Anesthesia
o Limiting Post-Cataract Surgery Payments
o Limiting Payments for Assistants-at-Surgery
o Correcting Overstatement in the Medicare Economic Index

MEDICARE PHYSICIAN PAYMENT REFORM ACT OF 1986

Procedures for Establishment of Special Limits on Reasonable Changes - Since the factors listed in the bill to be used by the Secretary in making inherent reasonableness determinations are consistent with those proposed in the Department's February 18, 1986 notice in the Federal Register, the bill as drafted would not add to current practice and could hamper its administration.

Development of Fee Schedule for Physicians' Services - We question the feasibility and advisability of attempting to define "justifiable differences" or of developing a federal index that could manipulate physician distribution incentives rather than allowing market forces to operate. Both tasks would be terribly complicated, expensive, intrusive and extremely difficult to complete by July 1, 1987.

Development and Use of HCFA Common Prcedure Coding System
Mandating the use of HCPCS in the outpatient setting is an important first step that will allow for the collection of meaningful data that could be used in future policy making.In regard collapsing codes and/or rebundling services, at this time, we are not certain that the necessary analyses could be completed in order to allow us to make changes by the July 1, 1987 deadline.

Medicare Economic Index for Physicians' Services - To phase in the proposed adjustment over two years would reduce the level of expected savings and continue payments at an unjustified level.

I AM PLEASED TO BE HERE TODAY TO DISCUSS OUR FY 1987 PROPOSAL IN THE AREA OF MEDICARE PHYSICIAN PAYMENT AND TO PROVIDE OUR PRELIMINARY VIEWS ON THE MEDICARE PHYSICIAN PAYMENT REFORM ACT OF 1986.

BACKGROUND

AS A RESULT OF BOTH THE DROP IN ADMISSIONS AND LENGTH OF STAY RESULTING FROM THE IMPLEMENTATION OF THE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (PPS) AND THE IMPACT OF THE FEE FREEZE MANDATED BY DEFRA, SOME PROGRESS WAS MADE IN REDUCING THE RATE OF GROWTH IN MEDICARE PAYMENTS FOR PHYSICIANS' SERVICES. IN FY 1984, THESE PAYMENTS GREW AT A RATE THAT WAS MORE THAN ONE THIRD SLOWER THAN THAT OF THE PREVIOUS TEN YEARS. ACCORDING TO THE 1986 TRUSTEES' REPORT, IN FY 1985, THE RATE OF GROWTH DECLINED TO 10.5 PERCENT.

ALTHOUGH PROGRESS HAS BEEN MADE ON REDUCING THE RATE OF GROWTH IN SPENDING FOR MEDICARE PHYSICIANS' SERVICES, THERE IS STILL CAUSE FOR CONCERN:

-- DURING THE MOST RECENT TWELVE-MONTH PERIOD (MARCH 85 - FEBRUARY 86) BENEFIT OUTLAYS BY OUR CARRIERS, WHICH WOULD INCLUDE PAYMENTS FOR PHYSICIAN AND OTHER MEDICAL SERVICES AND INDEPENDENT LABS, GREW AT A RATE OF 15.8 PERCENT.

-- ALTHOUGH THE FREEZE CONTROLLED THE PRICE OF SERVICES, GROWTH OF UTILIZATION/INTENSITY STILL REMAINS AN ISSUE;

- THE PHYSICIAN COMPONENT OF THE CPI IS STILL GROWING FASTER THAN THE OVERALL CPI. IN FY 1985, IT INCREASED BY 5.8 PERCENT WHILE THE OVERALL CPI INCREASE WAS 5.7 PERCENT.

-- IN THE 1986 TRUSTEES' REPORT, THE BOARD NOTED "WITH CONCERN THE RAPID GROWTH IN THE COSTS OF THE PROGRAM" AND RECOMMENDED "THAT CONGRESS CONTINUE TO WORK TO CURTAIL THE RAPID GROWTH IN THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM."

FY 1987 BUDGET PROPOSALS AND COBRA

AS I STATED DURING MY LAST APPEARANCE BEFORE THIS SUBCOMMITTEE, THIS ADMINISTRATION IS COMMITTED TO CAPITATION AS THE BEST MEANS TO ACHIEVE PHYSICIAN PAYMENT REFORM. CAPITATION APPROACHES MOVE AWAY FROM INTRUSIVE REGULATORY SCHEMES FOR CONTROLLING COSTS AND INSTEAD UTILIZE INCREASED COMPETITION AND CONSUMER CHOICE. IN THIS WAY, CAPITATION ALLOWS US TO ADDRESS BOTH PRICE AND UTILIZATION/INTENSITY OF SERVICES WHILE STILL PROVIDING QUALITY CARE.

IN ORDER TO ADVANCE THIS POLICY, WE HAVE PROPOSED, IN OUR FY 1987 BUDGET, TO EXPAND THE CAPITATION OPTIONS AVAILABLE TO OUR

BENEFICIARIES. WE HAVE ALSO PROPOSED STEPS THAT CAN BE TAKEN IN THE NEAR TERM TO ADDRESS SOME OF THE PROBLEMS OF CPR AND TO MAINTAIN CONSTRAINT ON SPENDING FOR PHYSICIANS' SERVICES. CONGRESS HAS ALREADY TAKEN SOME ACTIONS IN THIS AREA BY ENACTING COBRA. HOWEVER, WE BELIEVE THAT FURTHER STEPS ARE REQUIRED. LET ME BRIEFLY HIGHLIGHT OUR PHYSICIAN PAYMENT INITIATIVES.

VOUCHER BILL - MR. CHAIRMAN, WE ARE PLEASED THAT ON DECEMBER 18, 1985, YOU INTRODUCED S.1985, THE ADMINISTRATION'S VOUCHER PROPOSAL. IN THIS BILL, WE WILL BUILD ON THE REFORMS TO HMO/CMP FINANCING ENACTED IN TEFRA. S.1985 WOULD:

-- EXPAND THE POOL OF ENTITIES THAT COULD QUALIFY FOR CAPITATED PAYMENTS BY ALLOWING INDEMNITY INSURERS AS WELL AS HMOS AND CMPS TO PROVIDE ALTERNATIVE COVERAGE;

-- MAKE ENROLLMENT IN PRIVATE PLANS MORE ATTRACTIVE TO BENEFICIARIES BY ALLOWING EMPLOYERS TO COMBINE THE MEDICARE PAYMENT WITH THEIR OWN PREMIUMS FOR ANNUITANTS TO SECURE A UNIFORM PLAN WITHOUT DUPLICATIVE COVERAGE, AND

-- ELIMINATE CERTAIN CURRENT REQUIREMENTS THAT ARE OVERLY RIGID, SUCH AS THE REQUIREMENT THAT HMOS AND CMPS OFFER THE ACTUAL MEDICARE BENEFIT PACKAGE. SUBJECT TO

A TEST OF ACTUARIAL EQUIVALENCE OF BENEFITS, PLANS WOULD BE FREE TO RESTRUCTURE THE MEDICARE BENEFIT PACKAGE.

INSURERS HAVE EXPRESSED INTEREST IN BECOMING HEALTH BENEFIT PLANS UNDER OUR VOUCHER PROPOSAL. IN ADDITION, SOME MAJOR EMPLOYERS AND UNIONS HAVE DEVELOPED OR ARE IN THE PROCESS OF DEVELOPING PLANS TO BE AT-RISK FOR THE MEDICARE BENEFIT PACKAGE FOR THEIR ANNUITANTS.

REDUCE PAYMENTS FOR OVERPRICED PROCEDURES - UNDER CPR, NEW PROCEDURES TEND TO BE PRICED HIGH AT THEIR INTRODUCTION IF SPECIAL SKILLS AND OR A LARGE AMOUNT OF PROFESSIONAL TIME IS REQUIRED. HOWEVER, AFTER THE PROCEDURE BECOMES MORE ROUTINE AND OR TECHNOLOGICAL IMPROVEMENTS REDUCE THE AMOUNT OF TIME REQUIRED, INITIAL PAYMENT LEVELS ARE GENERALLY MAINTAINED. UNLIKE OTHER SECTORS OF THE ECONOMY WHERE SUCH CHANGES WOULD RESULT IN A DROP IN PRICES, BECAUSE OF CPR THERE IS A "DOWNWARD STICKINESS" IN FEES.

ON FEBRUARY 16, WE ISSUED A NPRM WHICH DESCRIBED THE CONDITIONS UNDER WHICH THE SECRETARY COULD USE "INHERENT REASONABLENESS" AUTHORITY TO ESTABLISH EITHER SPECIAL METHODOLOGIES OR SPECIFIC DOLLAR LIMITS WHEN THE FEE PAID FOR A PARTICULAR SERVICES UNDER CPR IS INHERENTLY UNREASONABLE. USING THESE CONDITIONS, THE SECRETARY WILL ISSUE NOTICES ON

SPECIFIC PROCEDURES. EXAMPLES OF PROCEDURES WHICH HAVE BEEN CITED AS POTENTIALLY OVERPRICED INCLUDE CATARACT SURGERY, CORONARY ARTERY BYPASS SURGERY AND PACEMAKER PROCEDURES. WE BELIEVE THAT OUR APPROACH IS CONSISTENT WITH SECTION 9304 OF COBRA WHICH DEALT WITH "INHERENT REASONABLENESS".

REDUCE PAYMENTS FOR STANDBY ANESTHESIA - AS WAS POINTED OUT IN A RECENT INSPECTOR GENERAL STUDY, THE SAME PAYMENT METHODOLOGY IS USED FOR ANESTHESIA SERVICES REGARDLESS OF WHETHER AN ANESTHESIOLOGIST ADMINISTERS GENERAL ANESTHESIA OR ONLY STANDS-BY AND MONITORS THE GENERAL CARE OF THE PATIENT WHILE THE SURGEON PERFORMS LOCAL ANESTHESIA, EVEN THOUGH THE RISKS AND THE LEVEL OF SERVICE PROVIDED IN THE LATER CASE ARE LOWER. WE ARE PROPOSING THAT THE RATE PAID FOR STANDBY ANESTHESIA SERVICES BE REDUCED.

LIMIT POST-CATARACT SURGERY PAYMENTS - BASED ON A GAO STUDY, WE HAD TWO PROPOSALS IN THIS AREA. THE FIRST, INCLUDED IN COBRA, WOULD REQUIRE CARRIERS TO USE INHERENT REASONABLENESS AUTHORITY TO SET SEPARATE AND MORE APPROPRIATE REASONABLE CHARGE ALLOWANCES FOR PROSTHETIC LENSES AND THE RELATED PROFESSIONAL SERVICES. THE SECOND COMPONENT OF THIS INITIATIVE, WHICH WE HAVE ALREADY IMPLEMENTED THROUGH A CARRIER MANUAL INSTRUCTION, WOULD REQUIRE REVIEW OF THE MEDICAL NECESSITY OF CLAIMS FOR REPLACEMENT CATARACT LENSES BEYOND ONE PER YEAR.

LIMIT PAYMENTS FOR ASSISTANTS-AT- SURGERY - ON JANUARY 1, WE IMPLEMENTED A PRE-PAYMENT REVIEW FOR THE MEDICAL NECESSITY OF ALL CLAIMS FOR ASSISTANTS-AT-SURGERY FOR CATARACT PROCEDURES. IN THE FY 1987 BUDGET, WE PROPOSED TO EXTEND THIS REVIEW TO OTHER PROCEDURES EFFECTIVE OCTOBER 1. CONGRESS ADDRESSED THIS ISSUE IN COBRA BUT WITH A DIFFERENT APPROACH. INSTEAD OF UTILIZING A PREPAYMENT SCREEN, COBRA MANDATED THAT PRIOR AUTHORIZATION BE RECEIVED IN ORDER FOR PAYMENT TO BE MADE FOR ASSISTANTS AT SURGERY FOR CATARACT PROCEDURES. WE ARE CURRENTLY STUDYING WHETHER PRIOR AUTHORIZATION WOULD BEST BE HANDLED BY OUR CONTRACTORS OR BY THE PROS AND WHAT ADJUSTMENTS NEED TO BE MADE TO EXISTING WORKLOADS, BUDGETS AND CONTRACTS TO MAKE THIS HAPPEN.

CORRECT OVERSTATEMENT OF THE MEDICARE ECONOMIC INDEX - THE ADMINISTRATION IS MAKING THIS PROPOSAL IN ORDER TO COMPLY WITH THE SECRETARY'S STATUTORY RESPONSIBILITY TO USE "APPROPRIATE ECONOMIC INDEX DATA" WHEN DETERMINING PREVAILING CHARGE LEVELS. THE USE OF THE HOUSING COMPONENT OF THE CPI RATHER THAN THE RENTAL EQUIVALENCE COMPONENT IS NOT JUSTIFIED GIVEN THAT MOST PHYSICIANS DO NOT OWN THE BUILDINGS IN WHICH THEY PRACTICE. REBASING THE MEI ON RENTAL EQUIVALENCE WILL ALLOW US TO CORRECT THIS SERIOUS OVERSTATEMENT IN THE OFFICE PRACTICE EXPENSE PORTION OF THE MEI.

COBRA CHANGES IN THE AREA OF PHYSICIAN PAYMENT PRESENT US WITH

A POTENTIAL DILEMMA IN IMPLEMENTING OUR PROPOSAL. OUR GENERAL COUNSEL IS REVIEWING WHETHER THE COBRA MANDATE THAT NON-PARTICIPANTS IN 1987 BE SUBJECT TO THE PREVAILING CHARGE LEVELS (LESS THE ONE PERCENTAGE POINT ADD-ON) OF PARTICIPANTS DURING 1986 DELAYS THE EFFECT OF THE TECHNICAL CORRECTION BY ONE YEAR FOR NON-PARTICIPANTS. IF SO, WHEN WE WOULD BE ADJUSTING THE MEI FOR THE FEE SCREEN YEAR BEGINNING JANUARY 1, 1987, IT WOULD ONLY IMPACT ON PARTICIPANTS. AS A RESULT, PARTICIPANTS WOULD GET A SMALLER INCREASE IN THEIR PREVAILING CHARGE LEVELS THAN WOULD NON-PARTICIPANTS.

WE BELIEVE THAT NARROWING THE DIFFERENTIAL BETWEEN PARTICIPANTS AND NON-PARTICIPANTS FOR ONE YEAR, WHICH WOULD OCCUR IF THE ADJUSTMENT IN THE MEI WERE NOT IMPLEMENTED SIMULTANEOUSLY, IS NOT THE PREFERRED WAY TO IMPLEMENT THIS CORRECTION. IN GENERAL, WE BELIEVE THAT WHEN THE JUSTIFICATION EXISTS FOR DOING SO (E.G., THROUGH THE USE OF INHERENT REASONABLENESS AUTHORITY), THE SECRETARY SHOULD HAVE THE AUTHORITY TO ADJUST THE PREVAILING CHARGES OF NOT ONLY PARTICIPATING BUT ALSO OF NON-PARTICIPATING PHYSICIANS.

IT IS IMPORTANT TO KEEP IN MIND, THAT EVEN WITH ALL OF OUR BUDGET PROPOSALS, BUDGET OUTLAYS FOR PHYSICIAN SERVICES WILL STILL INCREASE BY CLOSE TO 7 PERCENT. COMPARED TO THE FUNCTIONS IN THE BUDGET, THIS IS THE SECOND LARGEST INCREASE -- LARGER THAN THAT PROPOSED FOR NATIONAL DEFENSE AND INTEREST

ON THE DEBT.

FINALLY, IN REGARD TO THE PHYSICIAN PAYMENT PROVISIONS OF COBRA, WE ARE DOING OUR BEST TO MEET THE DEADLINES PROVIDED IN STATUTE FOR THE PARTICIPATION PROGRAM ENROLLMENT PERIOD AND FOR THE FEE UPDATE. LETTERS WENT OUT TO ALL PHYSICIANS AND SUPPLIERS MORE THAN TWO WEEKS AGO DETAILING THE PROVISIONS OF COBRA AND THE INCENTIVES FOR BECOMING OR CONTINUING AS A PARTICIPATING PHYSICIAN. HOWEVER, YOU SHOULD BE AWARE THAT THERE WILL PROBABLY BE DELAYS IN PUTTING THE NEW FEE SCREEN IN PLACE. SINCE PARTICIPATION STATUS WILL DETERMINE THE PREVAILING CHARGE A PHYSICIAN'S SERVICES WILL BE SUBJECT TO, WE CANNOT BEGIN MAKING PAYMENTS UNTIL WE HAVE IDENTIFIED ALL PARTICIPANTS AND HAVE INCLUDED THIS INFORMATION IN OUR PAYMENT FILES. THIS WILL BE IMPOSSIBLE TO DO BY MAY 1 BECAUSE PHYSICIANS CAN BE INCLUDED IN THE PARTICIPATION PROGRAM AS LONG AS THEY SEND IN A CONTRACT THAT IS POSTMARKED APRIL 30TH.

WE PLAN TO RUN THE NEXT PARTICIPATING PHYSICIAN PROGRAM ENROLLMENT PERIOD DURING THE MONTH OF NOVEMBER IN ORDER TO AVOID HAVING ANOTHER DELAY IN UPDATING THE PAYMENT SCREENS ON JANUARY 1.

MEDICARE PHYSICIAN PAYMENT REFORM ACT OF 1986

MR. CHAIRMAN, THROUGHOUT THIS ADMINISTRATION, THIS SUBCOMMITTEE UNDER YOUR LEADERSHIP HAS ENACTED SIGNIFICANT

HEALTH POLICY REFORMS THAT ARE PART OF A SYSTEM-WIDE REVOLUTION IN THE HEALTH CARE MARKET. AS I STATED EARLIER, WE BELIEVE THAT MORE NEEDS TO BE DONE. A NUMBER OF THE PROVISIONS IN THE BILL THAT YOU HAVE DRAFTED WITH SENATORS DOLE AND BENTSEN ARE CONSISTENT WITH THE PROPOSALS IN THE PRESIDENT'S FY 1987 BUDGET. WE BELIEVE THAT ONE MODIFICATION WOULD IMPROVE THE BILL. WE HOPE THAT THIS IS ONLY THE BEGINNING OF A DISCUSSION IN REGARD TO NEEDED REFORMS.

I WOULD NOW LIKE TO PROVIDE OUR PRELIMINARY REACTION TO THE THRUST OF THE BILL'S PROVISIONS.

SECTION 2 - PROCEDURES FOR ESTABLISHMENT OF SPECIAL LIMITS ON REASONABLE CHANGES

AS I STATED EARLIER, OUR INITIATIVES IN THE AREA OF OVER-PRICED PROCEDURES WOULD BE IMPLEMENTED THROUGH THE USE OF THE SECRETARY'S INHERENT REASONABLENESS AUTHORITY. WE INTEND TO USE AND ARE CURRENTLY EXAMINING THE COMMENTS ON OUR PROPOSED REGULATION AS WELL AS THE UNDERLYING STATUTORY LANGUAGE, TO SEE HOW THIS CONCEPT CAN BEST BE CLARIFIED FOR ITS OPERATIONAL USE. SINCE THE FACTORS LISTED IN THE BILL TO BE USED BY THE SECRETARY IN MAKING INHERENT REASONABLENESS DETERMINATIONS ARE CONSISTENT WITH THOSE PROPOSED IN THE DEPARTMENT'S FEBRUARY 18, 1986 NOTICE IN THE *FEDERAL REGISTER*, THE BILL AS DRAFTED WOULD NOT ADD TO CURRENT PRACTICE AND COULD HAMPER ITS ADMINISTRATION. FOR EXAMPLE, ALTHOUGH THE BILL WOULD MANDATE

A 60 DAY COMMENT PERIOD, WE BELIEVE THAT A SPECIFIC LENGTH OF TIME SHOULD NOT BE SPECIFIED IN STATUTE. INSTEAD, WE SHOULD BE GOVERNED BY GENERAL STANDARDS OF REASONABLENESS THAT APPLY TO ALL NOTICE AND COMMENT PROCEDURES.

SECTION 3 - DEVELOPMENT OF FEE SCHEDULE FOR PHYSICIANS' SERVICES

IN TESTIMONY BEFORE THIS SUBCOMMITTEE ON DECEMBER 6, I NOTED THAT FEE SCHEDULES ARE INHERENTLY REGULATORY IN NATURE, AND THEREFORE ARE COUNTER TO ADMINISTRATION POLICY. HOWEVER, CONGRESS, IN SECTION 9305 OF COBRA, MANDATED THAT THE SECRETARY DEVELOP A RELATIVE VALUE SCALE FOR PHYSICIANS' SERVICES. HCFA IS FUNDING A COOPERATIVE AGREEMENT WITH HARVARD UNIVERSITY TO CONDUCT A COMPREHENSIVE STUDY OF THE RELATIVE VALUES OF PHYSICIAN SERVICES. USING A CONSENSUS APPROACH, A RVS FOR APPROXIMATELY 200 PROCEDURES WITHIN AND ACROSS 12 MEDICAL AND SURGICAL SPECIALTIES WILL BE DEVELOPED TAKING INTO CONSIDERATION COMPLEXITY, TIME, PRACTICE EXPENSE AND SPECIALTY TRAINING INPUTS.

SECTION 3 WOULD ADD AN ADDITIONAL REQUIREMENT TO THE RVS STUDY THAT AN INDEX BE DEVELOPED "TO REFLECT JUSTIFIABLE DIFFERENCES IN THE COST OF PRACTICE BASED ON GEOGRAPHIC LOCATION WITHOUT EXACERBATING THE GEOGRAPHIC MALDISTRIBUTION OF PHYSICIANS". WE QUESTION THE FEASIBILITY AND ADVISABILITY OF ATTEMPTING TO DEFINE "JUSTIFIABLE DIFFERENCES" OR OF DEVELOPING A FEDERAL

INDEX THAT COULD MANIPULATE PHYSICIAN DISTRIBUTION INCENTIVES RATHER THAN ALLOWING MARKET FORCES TO OPERATE. THE RECENT EXPERIENCE SURROUNDING THE CONGRESSIONALLY MANDATED URBAN/RURAL PAYMENT DIFFERENTIAL UNDER HOSPITAL PPS RAISES SERIOUS QUESTIONS ABOUT THE WISDOM OF CREATING SUCH AN INDEX. BEYOND THE MERITS OF THE STUDIES, BOTH TASKS WOULD BE TERRIBLY COMPLICATED AND EXTREMELY DIFFICULT TO COMPLETE BY JULY 1, 1987. IN ADDITION, THEY WOULD BE EXPENSIVE AND INTRUSIVE UNDERTAKINGS.

SECTION 4 - DEVELOPMENT AND USE OF HCFA COMMON PRCEDURE CODING SYSTEM

THIS SECTION HAS TWO PROVISIONS. IT WOULD MANDATE THE USE OF HCPCS IN HOSPITAL OUTPATIENT DEPARTMENT BILLINGS. IT WOULD ALSO REQUIRE THAT HCFA SIMPLIFY THE PAYMENT METHODOLOGY UNDER THE HCFA COMMON PROCEDURE CODING SYSYEM (HCPCS).

WE AGREE WITH THE CHAIRMAN OF THIS SUBCOMMITTEE THAT ACTION NEEDS TO BE TAKEN TO CONTROL THE RATE OF GROWTH IN SPENDING FOR SERVICES PROVIDED IN HOSPITAL OUTPATIENT DEPARTMENTS. OUR ACTUARIES IN THE 1986 TRUSTEE'S REPORT PROJECTED A RATE OF GROWTH OF 41.4 PERCENT IN FY 1986 IN OUTPATIENT SERVICES. FOR TOO LONG REFORM OF HOSPITAL OUTPATIENT DEPARTMENT HAS BEEN FRUSTRATED BY THE LACK OF A COMMON PROCEDURE CODING SYSTEM. MANDATING THE USE OF HCPCS IN THIS SETTING IS AN IMPORTANT

FIRST STEP THAT WILL ALLOW FOR THE COLLECTION OF MEANINGFUL DATA THAT COULD BE USED IN FUTURE POLICY MAKING. WE STRONGLY AGREE WITH THE OBJECTIVES OF THE CHAIRMAN ON THIS PROPOSAL, AND WE ARE INVESTIGATING THE IMPLEMENTATION OF THIS REQUIREMENT UNDER EXISTING AUTHORITY.

IN REGARD TO THE LATTER PROVISION, WHILE THERE IS SOME POTENTIAL FOR COLLAPSING CODES AND/OR REBUNDLING SERVICES GIVEN THE 7,500 CODES UNDER WHICH PHYSICIANS CAN BILL IN HCPCS, SUCH CHANGES WOULD CLEARLY NEED TO BE MADE IN A WAY THAT DID NOT INCREASE MEDICARE OUTLAYS FOR PHYSICIAN SERVICES. AT THIS TIME, WE ARE NOT CERTAIN THAT THE NECESSARY ANALYSES COULD BE COMPLETED IN ORDER TO ALLOW US TO MAKE CHANGES BY THE JULY 1, 1987 DEADLINE.

SECTION 5 - MEDICARE ECONOMIC INDEX FOR PHYSICIANS' SERVICES

AS I INDICATED EARLIER, THE ADMINISTRATION IS PLANNING TO ADJUST THE MEI IN ORDER TO COMPLY WITH THE SECRETARY'S STATUTORY RESPONSIBILITY TO USE "APPROPRIATE ECONOMIC INDEX DATA" WHEN DETERMINING INCREASES IN PREVAILING CHARGE LEVELS. THE ADMINISTRATION'S PROPOSAL IS ESTIMATED BY OUR ACTUARIES TO SAVE $175 MILLION IN FY 1987 AND $250 MILLION IN FY 1988. TO PHASE IN THE PROPOSED ADJUSTMENT OVER TWO YEARS WOULD REDUCE THE LEVEL OF EXPECTED SAVINGS AND CONTINUE PAYMENTS AT AN UNJUSTIFIED LEVEL.

IN ADDITION, IT WOULD BE DESIRABLE IF THE BILL CLARIFIED THE ISSUE THAT I RAISED EARLIER WITH REGARD TO THE INTERACTION OF THE PHYSICIAN PAYMENT PROVISIONS OF COBRA AND OUR MEI CORRECTIONS, SO THAT THE REVISION WOULD BE FULLY AND SIMULANTEOUSLY IMPLEMENTED FOR BOTH PARTICIPATING AND NON-PARTICIPATING PHYSICIANS ON JANUARY 1, 1987. WE WOULD BE HAPPY TO WORK WITH THIS SUBCOMMITTEE TO DEVELOP ADDITIONAL LANGUAGE WHICH WOULD ELIMINATE THIS PROBLEM.

CONCLUSION

IN SUMMARY, COBRA ADDRESSED SOME OF THE INITIATIVES PROPOSED IN THE PRESIDENT'S FY 1987 BUDGET. PARTS OF THE MEDICARE PHYSICIAN PAYMENT REFORM ACT OF 1986 WOULD ENACT ADMINISTRATIVE MEASURES WE ARE CURRENTLY TAKING TO CORRECT PROBLEMS WITH CPR AND WOULD HELP TO MAINTAIN CONSTRAINT ON SPENDING FOR PHYSICIANS' SERVICES. WE LOOK FORWARD TO CONTINUING TO WORK WITH THIS SUBCOMMITTEE. WE STILL BELIEVE, HOWEVER, THAT THE LEVEL OF SAVINGS PROPOSED IN OUR FY 1987 BUDGET ARE REQUIRED AND THAT THE MODIFICATIONS MENTIONED EARLIER WOULD SIGNIFICANTLY IMPROVE THE BILL.

OVER THE LONGER TERM, SYSTEM REFORM CAN ONLY BE ACHIEVED THROUGH OUR INITIATIVES IN THE AREA OF CAPITATION. IT IS ONLY THROUGH CAPITATION THAT WE CAN STRENGTHEN THE COMPETITIVE FORCES IN OUR HEALTH CARE SYSTEM. COMPETITION AND CONSUMER CHOICE, RATHER THAN MORE ELABORATE REGULATORY OPTIONS, ARE THE

BEST WAYS TO ACHIEVE THE PROVISION OF QUALITY CARE SERVICES WHILE RESTRAINING THE GROWTH OF SPENDING FOR HEALTH CARE. THROUGH THE EXPANSION OF CAPITATION OPTIONS, BENEFICIARY CHOICE WILL HAVE A GREATER IMPACT ON THE HEALTH CARE MARKET AND THAT IS WHERE THE LOCUS OF DECISIONMAKING RIGHTFULLY BELONGS.

I THANK YOU FOR THE OPPORTUNITY TO DISCUSS THESE ISSUES WITH YOU. I'D BE HAPPY TO RESPOND TO ANY QUESTIONS THAT YOU MAY HAVE.

STATEMENT OF PAUL B. GINSBURG, PH.D., SENIOR ECONOMIST, THE RAND CORP., WASHINGTON, DC

Dr. GINSBURG. Thank you, Mr. Chairman.

We have been aware of the serious distortions in Medicare's payments to physicians for some time, but we have been reluctant to address the problems because of concerns about inadvertently causing problems for beneficiaries in the process.

With an increasing supply of physicians and the competitive effects of the Medicare participating-physician category, changes in payments to physicians can now be given serious consideration.

While the process of rationalizing fees will undoubtedly lead to some beneficiaries paying more, a careful process is likely to leave beneficiaries, on the whole, better off.

The Medicare Payment Reform Act of 1986 would make a substantial contribution towards rationalizing Medicare physician payments by constructing a framework for careful consideration of changes in relative payments. It would clarify the authority of the Secretary of Health and Human Services to depart from the CPR process, thus enabling bolder changes.

The bill would ensure that the process through which payment rates are changed would be open to comment by interested parties and would benefit from the advice of a wide range of experts.

If this process is to succeed, the changes must be carefully grounded in objective analysis, with the key parties of interest accorded time and the opportunities to make their views known.

The role prescribed for the Physician Payment Review Commission would be an effective way to accomplish this. Representation on the Commission would be a potentially more effective way for key interest groups to participate in the process, providing a forum for negotiation among them.

The Commission, through both its membership and its staff, would bring needed expertise in economics and medicine into the deliberation.

The overall approach pursued by this bill is a prudent one. Rather than calling for a wholesale revamping of relative payments, it provides for a process of selecting for adjustments those procedures whose relative payments are most out of line. This would lead to changes that achieve a higher degree of acceptance within the medical community, allow more careful consideration of impacts on beneficiaries, and permit midcourse corrections in the approach.

At the same time as a framework is being set up to change relative payments, consideration should be given to making the participating physician category more effective. Options to do this include increased efforts at informing beneficiaries, advance disclosure of charges to beneficiaries, and increasing payment differentials between participating physicians and others.

Not all situations will lend themselves to this competitive approach, however. When a hospital has an exclusive arrangement with a radiology group, for example, requiring assignment might have to be considered.

Capitation is likely to play an increasing role in Medicare over time. While the basic policy is in place and is a sound one, refinements in pricing formulas to address biased election is needed now. Otherwise, Medicare may inadvertently overpay plans, or the plans may find that windfall gains and losses from selection overwhelm the effects of good management of costs.

Capitation payments to large employers for eligible retirees, an aspect of the bill recently introduced by Senator Durenberger, is an attractive tool to avail more Medicare beneficiaries of opportunities to benefit from recent innovations in health care managements. Employer-specific adjustments to offset the effects of selection of corporate and union volunteers for such a program would be required to present an increase in Medicare outlays, however.

Thank you.

Senator DURENBERGER. Thank you, Paul.

[The prepared statement of Dr. Ginsburg follows:]

STATEMENT OF

PAUL B. GINSBURG, PH.D

Senior Economist

The Rand Corporation*

before the

Subcommittee on Health

Committee on Finance

United States Senate

April 25, 1986

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*The views expressed are my own. They do not represent those of the Rand Corporation or its research sponsors.

Mr. Chairman, I am pleased to have the opportunity to discuss with the Subcommittee options for reform of Medicare payment of physicians and in particular, the "Medicare Physician Payment Reform Act of 1986".

BACKGROUND

Prior to 1984, when the Congress turned Medicare physician payment in a new direction with the participating physician concept, policy had been unchanged for more than a decade. A consensus had been evolving concerning the nature of the problems of the payment system, but we were fearful about unintended consequences of the solutions.

Many recognized the irrational results of Medicare's "customary, prevailing, and reasonable" system: how new procedures tended to be overpaid relative to more established procedures; that earnings of physicians in specialties deemed to be in excess supply were so high relative to those of other physicians that strong financial incentives for additional physicians to train for those specialties are present; and how geographic differences in payment bore little relation to variations in the costs of practice or imbalances between supply and demand.

Despite this consensus, concern for the vulnerability of beneficiaries to additional charges by physicians led to hesitancy in pursuing reforms. If payments in New York City were reduced while those in North Dakota were increased, physicians in the former might not lower their charges but leave their patients responsible for the increased differences between actual and allowed charges. Concerns with the integrity of procedure coding, especially visits, also limited initiatives. Those physicians experiencing reduced rates of payment under Medicare would have opportunities to offset the effects on their revenues by coding differently--for example a limited office visit coded instead as an intermediate visit.

Circumstances have changed, however, and we are now in a somewhat better position to contemplate reforms of the Medicare physician payment system. Beneficiaries are likely to be less vulnerable to paying more when Medicare pays less than in the past. Increasing physician supply is the principal development behind this. Physicians need Medicare patients' business more than in the past. The increased acceptability of using market forces to contain costs of medical care is another factor.

The key event to date has been the participating physician designation. By making it easier for beneficiaries to favor those physicians that accept assignment, physicians have a stronger incentive to do so. The upshot is Medicare and its beneficiaries purchasing physicians' services at a better price. The assignment rate increased from 53.9 percent in 1983 to 68.5 percent in the first quarter 1985, despite the freeze on fees.[1] The recent decision of the Congress to allow a larger update in payments for participating physicians will strengthen the incentives for physicians to sign agreements and represents an additional step towards increasing the market power of Medicare and its beneficiaries.

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[1] Part of the increase reflects the implementation of mandatory assignment for laboratory claims. The assignment rate for physicians' services in 1985 was 63.9 percent. A comparable number for 1983 is not available.

The extent to which these changes will succeed is an open question. Much depends on the degree to which beneficiaries take participation status into account when they choose physicians. More physicians will sign participation agreements only if they notice a difference in their Medicare caseload.

A number of factors temper optimism about changes in beneficiary behavior, however. First, many with chronic illness are reluctant to change physicians. Second, the extensive use of private supplemental coverage will limit progress in this area by removing incentives from many to seek participating physicians. In 1977, 80 percent of beneficiaries had either private supplemental coverage or eligibility for Medicaid. While many of the private policies did not cover charges in excess of those allowed by Medicare, a significant number did pay charges up to the private carrier's own screens for reasonableness. In that year, 41 percent of beneficiaries had such coverage for inpatient physician services and 29 percent had it for office visits.

Success in strengthening the market power of beneficiaries is an important precursor to rationalizing Medicare's system of physician payment. Otherwise, more regulatory approaches, such as mandatory assignment, will have to be considered.

MEDICARE PHYSICIAN PAYMENT REFORM ACT OF 1986

The bill before the Subcommittee today would make a substantial contribution towards rationalizing Medicare physician payment by constructing a framework that is needed to do so.

It would give the Secretary of Health and Human Services clear authority to alter payment rates upon evidence of significant imbalances. This would enable the Secretary to pursue a much bolder course than might be the case under existing authority.

The bill would ensure that the process through which payment rates are changed would be open to comment by interested parties and would benefit from the advice of a wide range of experts. If this process is to succeed, the changes must be carefully grounded in objective analysis, with the key parties of interest accorded timely opportunities to make their views known.

The role prescribed for the Physician Payment Review Commission would be an effective way to accomplish this. Representation on the Commission would be a potentially more effective way for key interest groups to participate in the process, providing a forum for negotiation among them. The Commission, through both its membership and its staff, would bring needed expertise in economics and medicine into the deliberation.

The bill would direct the Secretary to conduct two analytical tasks necessary for changing relative payments--

collection of cost of practice data that are required to consider changes in relative payments across geographic areas and simplification of the payment methodology under the HCFA Common Procedure Coding System. With the Administration indicating that its priorities are with increased use of capitation, the Congress needs to ensure that the analytic work most critical to reform of fee-for-service payment be performed in a timely manner. No matter how successful are initiatives to increase the use of capitation, the fee-for-service system will continue to play an important role in Medicare for the foreseeable future.

The overall approach pursued by this bill is a prudent one. Rather than calling for a wholesale revamping of relative payments, it provides for a process of selecting for adjustment those procedures whose relative payments are most out of line. This would lead to changes that achieve a higher degree of acceptance within the medical community and allow more careful consideration of impacts on beneficiaries.

ADDITIONAL STEPS

While rationalizing relative payments, the Congress could take additional steps to increase the market power of beneficiaries. This would limit the degree to which some of the reductions in relative payments were passed on to the beneficiaries.

A number of steps could be taken to increase assignment through the provision of better information to beneficiaries. HCFA could make greater efforts to explain participation to beneficiaries and provide them with handbooks of participating physicians--in much the same way that Preferred Provider Organizations (PPOs) disseminate information on physicians that they have agreements with. Information such as which hospitals the physician has staff privileges at and board certifications could make the handbook a more effective communications tool for what is essentially Medicare's preferred provider panel. With 29 million beneficiaries, such an effort would cost millions of dollars, but the potential gains to beneficiaries and to a $25 billion program are many times that. Unless we back the concept, it is unlikely to realize its important potential.

Price disclosure requirements could be effective in helping beneficiaries take participating status into account. For all nonemergent hospital admissions, any nonparticipating admitting physician would have to provide the beneficiary in advance with a written statement as to whether there would be charges in excess of those allowable by Medicare and an estimate of them. The admitting physician would have to disclose an estimate of additional charges by certain other physicians to be involved in the hospital stay, such as the anesthesiologist. Disclosure requirements would be difficult to enforce without an extensive effort to acquaint beneficiaries with them.

Offering payment in full to participating physicians (with the carrier collecting the deductible and coinsurance from private supplemental insurance, Medicaid, or the beneficiary) is an idea worthy of at least a demonstration. Since about 80 percent of beneficiaries have some supplemental coverage, much of the collection could be done without their direct involvement. I do have concerns, however, about the federal government's ability to collect from the beneficiaries, especially those with large debts resulting from a catastrophic illness. If the government did only as well as physicians do, it would make this a very costly incentive for participation.

Offering full payment is only one method of a general strategy of encouraging participation agreements through paying participating physicians more than those not signing agreements. Payment differentials during a period of budget stringency mean more generous payments for participating physicians and stronger incentives on the part of beneficiaries to change to them. Where beneficiaries do not have such opportunities, however, payment differentials could increase the financial burden on them.

Not all situations lend themselves to the use of better information and beneficiary incentives, however. Some hospitals have exclusive arrangements with a radiology group, for example, so patients in that hospital might have no ability to exercise a preference for a participating radiologist. Where such market power exists, the law might be changed to permit the use of countervailing power by Medicare--such as requiring assignment.

CAPITATION

I expect that capitation will ultimately play a much larger role in Medicare than it does today. While the basic framework and direction for using capitation in the Medicare program were established in the Tax Equity and Fiscal Responsibility Act of 1982 and are generally sound, two issues are worthy of attention in the short term. They are:

--refinements in the formulas to adjust the capitation amounts for the characteristics of enrollees, and

--capitation payments to large employers for Medicare beneficiaries participating in retirement health benefit plans.

Refine Capitation Rates

A serious risk to the potential of HMOs in Medicare is the inadequacy of current adjustments to capitation payments for risk factors. Medicare's average adjusted per capita cost (AAPCC) attempts to pay health plans 95 percent of what an enrollee's claims would have been had he or she remained in traditional Medicare. Thus, higher payments are made for an 85 year old enrollee than one who is 65. But the adjustments do not include factors such as the presence of chronic disease.

Studies of prior use of services among those first enrolling in HMOs have indicated the potential for a plan to draw a population that is not representative of the Medicare population in the area. A key factor in this phenomenon that researchers call "biased selection" is that those with heavy use of medical care are less willing than others to consider enrolling in an HMO when a change in physician is required. When HMOs draw a population of low users, this increases federal outlays because capitation payments are based claims by the average user.

But sometimes the opposite is the result. The research literature includes examples of IPA-model HMOs drawing higher-than-average users.

A substantial degree of biased selection poses serious risks to capitation arrangements. If the bias were towards low users, Medicare would suffer increased outlays. If some health plans draw high users while others draw low users, the financial implications of biased selection are likely to overwhelm the results of plan efficiency or lack of it, and discourage organizations from seeking to participate in risk contracts with Medicare.

Research is needed to develop practical measures of beneficiary health status to use in the setting of payment rates. Until such measures are ready for implementation, substantial progress could be made through the incorporation of data on utilization prior to enrollment in an HMO. Research sponsored by HCFA indicates that prior utilization is a good predictor of subsequent use. While incentive and data collection problems make the use of such measures questionable over the long term when many enrollees will have been served by HMOs for many years, prior utilization could be a very useful adjustment right now when most enrollees have recent experience in the fee-for-service system.

Capitation Payments to Employers

One provision of the Administration's voucher bill would allow large employers to receive Medicare capitation payments on behalf of their retirees. This has the potential of giving large numbers of beneficiaries access to the innovations in managed care that some large employers have been pioneering. Payments to employers avoid one of the most serious drawbacks to vouchers--the additional costs of marketing to individuals. Capitation rates would have to be tailored to each employer, however, because health status of retirees probably varies significantly by industry. Otherwise, the drain on the trust funds could be very large as only those employers whose eligible retirees were lower-than-average users of services would seek such contracts with Medicare.

Senator DURENBERGER. Dr. Hsiao?

STATEMENT OF WILLIAM C. HSIAO, PH.D., PROFESSOR OF ECONOMICS AND HEALTH POLICY, SCHOOL OF PUBLIC HEALTH, HARVARD UNIVERSITY, BOSTON, MA

Dr. HSIAO. Mr. Chairman, I am pleased to appear before your committee today.

In the interest of time, I will just give you a brief summary of my written statement. First I would just briefly outline the distorted incentives in the current payment system; second, I would summarize the impact of those distorted incentives; and, lastly, I will outline some brief recommendations.

In the United States we rely on the free enterprise market to determine the price of commodities and services. Physicians fees are no exception. We pay physicians based on what they charge, with some limitations.

However, I submit, the physician service market does not meet the basic conditions for a competitive market. First, because the wide spread of insurance coverages reduces the consumer's sensitivity to the fees physicians charge. Therefore, physicians do not compete directly on price.

Second, consumer sovereignty is also largely absent, because patients do not have adequate medical knowledge to choose medical services. Instead, they rely on doctors to make decisions for us.

Because of these imperfections in our marketplace, what emerged is a distorted price structure, and this distorted price structure has a profound impact on health care costs, on the quantity of services rendered, the availability to primary care doctors, and access of physicians services in rural communities.

Let me explain why this came about. The charges and payment rate tends to tilt in favor of surgical and technical procedures. My research and other people's research studies have found that, compared on the basis of time and effort required, surgical and technical procedures are compensated two to three times more than medical services. And in my testimony I provide some figures, in a table.

Therefore, this price structure gives incentives for physicians to perform more costly surgical and technical services which foster higher cost inflation.

Second, this price system that we have today provides incentives for medical school graduates to select higher compensated specialties, and leave less compensated specialties with a shortage of doctors. This is revealed in the shortage we have in primary care physicians, while there is a surplus of surgeons cut across most surgical specialties.

Then lastly, because of the imperfection in the physician marketplace, we find that where there are more physicians per capita the prices charged are higher. That is contradicting the fundamental economic law. Because of this phenomenon, physicians are not redistributing themselves from the oversupplied areas to undersupplied areas. If that redistribution is going on, at least it is going on at a very slow rate.

Therefore, I am making the following recommendations, and let me just mention the three major ones:

The first is to alter the basis of payment rates. As I mentioned earlier, the payment rates now for Medicare and the other programs are all based on the charges that physicians are making, and with some modifications.

Any payment system based on physician charges would institutionalize the distortions in the current system. Payments should be made based on some objective criteria produced through some kind of scientific method, such as the resource based relative value scale that has been developed.

A resource based relative value scale is needed regardless of what kind of payment we adopt. We need a better fundamental building block to compensate physicians equitably and fairly. This is true regardless of whether we use fee for service, a fee schedule, or physician DRG, or negotiation between preferred provider organizations and physicians.

Let me just mention that in the past 6 months I have received more calls from HMO's about our study, because they need an objective base to decide on how to compensate physicians in HMO's as well as to even set work performance standards.

Let me go on to quickly two other recommendations:

Second, I believe it is necessary to establish equitable payment rates across geographical areas. I submit that we need to provide a level playing field for physicians, not distort the economic incentives as to where they should locate their practices, particularly for the new physicians. The Canadian experience has taught us that just providing the same fee schedule in one province resulted in a migration to the rural areas.

Last, I submit that as a prudent purchaser of services, Medicare needs to examine closely the billing code. In recent years the billing code has tripled. This might be necessary in terms of identifying clinical conditions, but not necessarily necessary for reimbursement purposes.

Thank you very much.

Senator **Durenburger**. Thank you very much.

[The prepared statement of Dr. Hsiao follows:]

Statement before U.S. Senate Committee on Finance

by

William C. Hsiao

Professor of Economics and Health Policy
Harvard University

April 25, 1986

In the United States, we rely on the free enterprise competitive market to determine the prices of commodities and services. Physician fees are no exception. We pay physicians according to what they charge.

The physician service market, however, does not meet the basic conditions for a competitive market. The wide spread of insurance coverage reduces the consumer's sensitivity to the fees physicians charge. Physicians do not compete on prices. Consumer sovereignty is also largely absent because patients do not have adequate medical knowledge to choose medical services. Instead, we rely on doctors to make decisions for us. This places physicians in an autonomous and dominating role in the marketplace. Physicians, therefore, enjoy freedom to set their charges, decide the type of service to be provided, and influence the quantity of services patients receive. The recent price competition between insurance plans and HMOs has not produced direct price competition among physicians.

Meanwhile, the payment rates for physician services under Medicare and Medicaid have been largely based on what the doctors charge. These distorted prices produced by the imperfect marketplace have a profound impact on health care cost inflation, the quantity of services rendered, the availability of primary care doctors, and the accessibility of physician services in rural communities.

Higher health care cost and reduced quality.

Charges and payment rates are tilted in favor of surgical and technical procedures. Our research studies have found that when compared on the basis of time and effort required, surgical procedures are compensated two to three times more than medical services (see Table 1). This price structure provides incentive for doctors to perform the more costly procedures, which causes higher inflation. At the same time, many unnecessary surgical and technical services are rendered that have questionable value to the patient, sometimes resulting in complications and death.

The magnitude of this impact can be inferred by comparing the frequency of surgery under the fee-for-service system and under HMOs. Studies have found the differences range from 10 to 25 percent, particularly for discretionary procedures such as tonsilectomy and hysterectomy.

Maldistribution of specialists.

The distorted price structure provides incentives for medical school graduates to select higher-compensated specialties, while leaving less-compensated specialties with a shortage of doctors. We have a shortage of primary care physicians today, while there is an oversupply of surgical specialists. As shown by the study conducted by the Federal Government, we have a surplus of surgeons cutting across most surgical specialties, while we have a shortage of primary care physicians needed to render appropriate services to patients.

Shortage of physicians in rural areas while there is an oversupply in urban areas.

Because of the imperfections in the physician marketplace, we have observed an unusual phenomenon that contradicts the standard economic law. In a competitive marketplace, the greater number of sellers, the lower the price of the product. The opposite is true in the physician service market: the greater the number of physicians in a service area, the higher the price charged. This phenomenon is consistent with the theory that physicians occupy an autonomous and dominant position which allows them to set their prices to achieve a desired income level. When physicians can set prices withour adequate constraint by competition, there are no incentives then for physicians to redistribute themselves from over-supplied areas to under-supplied areas. This practice contributes to the shortage of doctors in rural communities and inner cities.

Recommended policies.

The following recommendations are made to achieve several public goals: contain health care cost inflation, improve quality of services, and improve the distribution of physicians.

A. Alter the basis of payment rates: Payment rates should not be based on the charges made by physicians because the market is imperfect. Any payment system based on physician charges would institutionalize the distortions in the current system. Payment should be based on objective criteria produced through scientific method, such as the resource-based relative value scale that is currently being developed. A resource-based relative value scale is needed regardless of what payment system the Congress adopts. We need a better base as the basic building block to compensate physicians equitably and fairly. This is true regardless whether we compensate physicians on a fee-for-service basis, by DRG by negotiation between the preferred provider organizations and physicians, or by capitation rates. Each method would require information as to the resource input costs for performing physician services.

Adoption of the resource-based relative value scales would moderate health care cost inflation and provide the incentives for physicians to choose the appropriate modality of treatment in caring for patients.

The current study on resource-based relative value scales, funded by the Health Care Financing Administration, is scheduled to be completed by July 1, 1988. The development of resource-based relative value scales is a complicated task that requires medical expertise, economic analysis, statistical information and cost analysis. The reliability and usefulness of the findings from this study would be impaired if insufficient time is allowed for the study. Therefore, it is imperative that the Congress allow sufficient time for this study to be completed before the Secretary of Health and Human Services is required to report on the findings of the relative value study. The Secretary may provide an interim report on or before July 1, 1987, but the final report to Congress should be made on or after July 1, 198[illegible], after the study is completed.

B. Establish equitable payment rates across geographical areas: The current price variation between geographical areas may be a major contributing cause to the shortage of doctors in rural communities and inner cities. A study should be done to identify the economic differences among geographic areas that would justify different payment rates. The study should take into account the differences in practice costs, cost of living, and supply of physicians. The Government can then use this information to establish fair and equitable payment rates that will help to reduce the shortage of physicians in some communities.

Congress should consider legislation that would offer bonus payments for physicians to locate in under-served areas. The Canadian experience shows that economic incentive can have a significant influence on new physicians as to where they locate their practices.

C. Control "billing code creep": Billing codes for physician services have increased three-fold in recent years. Fine distinctions are made in codes for physician services which encourage the fragmentation of services as well as encouraging physicians to label their services in such a way that would justify higher payment. Studies have found that billing code creep has been a significant contributing factor in the recent health care cost inflation. The current codes could be reduced significantly for payment purposes, while providing equitable compensation to physicians.

D. Set target budgets for physician services by geographical area: Physicians can set their prices as well as influence the quantity of services demanded by patients. Experience under the Medicaid program has shown that price regulation is not very effective in controlling physician expenditures because the volume of services is increased to compensate for any control in payment rates. Therefore, a target budget needs to be set in order to monitor the effectiveness of payment regulation.

E. Mandate demonstration projects on experimental methods of compensating physicians: The physician DRG payment system has merit because it reduces fragmentated billing and also a physician becomes the gatekeeper for the patient in a given episode of illness. However, there are serious technical and operational problems in the physician DRG payment method. Nonetheless, this approach has sufficient merit that the Government should conduct demonstration projects to learn how feasible it is to reimburse physicians on DRG basis.

Table 1

Comparison of Relative Values Calculated from 1983 Medicare Charges and Resource Inputs

General Surgery

	Charge-Based		Resource-Based	
	Charges	Ratio	Value	Ratio
Initial Complete Office Visit	$ 52	1.0	0.4	1.0
Initial Intermediate Hospital Visit	100	1.9	-	-
Appendectomy	550	10.6	1.0	2.5
Total Abdominal Hysterectomy	1,100	21.2	2.1	5.3

Cardiovascular Surgery

	Charges	Ratio	Value	Ratio
Initial Complete Office Visit	$ 80	1.0	0.5	1.0
Initial Intermediate Hospital Visit	110	1.4	-	-
Insertion of Pacemaker	1,060	13.3	1.6	3.2
Coronary Artery Bypass	3,000	37.5	7.5	15.0

Ophthalmology

	Charges	Ratio	Value	Ratio
Initial Comprehensive Eye Exam	50	1.0	0.5	1.0
Simple Extraction of Lens	1,100	22.0	1.5	3.0

From the Massachusetts Relative Value
Scale Study conducted by Harvard
University, School of Public Health.

Senator **DURENBERGER**. Dr. Ginsburg, Henry Desmarais argued that fee schedules are inherently regulatory and, in addition, counter to Administration policy. Dr. Hsiao just argued, and I think I argued in my questions to Dr. Desmarais, to the contrary, that while any set fee is regulatory in concept, that in fact as we are moving toward a capitated system this can be actually procompetitive or prochoice. What is your view?

Dr. **GINSBURG**. I regard a fee schedule as consistent with Medicare's evolving stance as a prudent purchaser, and I believe that that is a procompetitive measure. It makes competition among physicians easier by, as you indicated, giving some additional information to beneficiaries.

And it is a way, in a market where the consumers—the beneficiaries—are limited in their market power relative to that of the providers, to provide a countervailing market power. It gives consumers some additional ability to avoid high prices.

As Dr. Hsiao mentioned, many of these innovations in public programs, such as PPS and a fee schedule, provide the private sector with needed information to carry out its innovations, such as PPO's. So work in this area is of great use to the private sector as well.

Senator **DURENBURGER**. I think you well know that both Max and I have some deep concerns for the impact of moving to prospective systems, and you know he has a deep concern for the movement toward capitation on rural communities.

But the notion somehow is that there aren't geographic variations in physician services; but the reality seems to be that there are. I would suggest that the reality also is that those variations in fees encourage physicians to locate in high-fee areas, and those high-fee areas are not in rural America. If that wasn't true today, it is sure going to be true tomorrow.

What is your view of that?

Dr. **GINSBURG**. The geographic pattern of fees we have has discouraged physicians from responding to economic incentives. Basically, they can go to an over supplied area, not have a very large caseload, but still earn an adequate income, and thus not respond to the incentives to move to where there is less of a supply of physicians.

So I would think that a change in the geographic pattern of fees would encourage additional movement towards the rural areas.

Senator **DURENBERGER**. Dr. Hsiao, your friend Dr. Egdahl at Boston University argues that he can develop an RBS system in 6 months or a year, at the most. Why does your process take so much longer?

Dr. **HSIAO**. I think, if I understand correctly, Dr. Egdahl at Boston University intended to develop a relative value through a group-consensus process only with the physicians, and that is to ask the suppliers to decide among themselves what price they should charge.

The study we are conducting, funded by the Health Care Financing Administration, and with the assistance and participation of the American Medical Association, is based on the collection of some basic information and statistics through a survey, as well as consultation with physicians.

Senator **Durenberger**. Well, you have a technical component that consists of a telephone survey of a random sample of 1,200 to 1,500 physicians; that shouldn't take very long; and you have a medical component which consists of 12 technical consultant groups composed of expert physicians—that doesn't say anything about anybody other than what Dr. Egdahl is doing from medical and surgical specialties. Why does yours take so long?

Dr. **Hsiao**. Mr. Chairman, what we attempt to do in this study is to measure the resource input costs for each service rather than to just bring about a consensus. And to measure that resource input cost requires the improvement and development of a methodology, and that takes several months.

Conducting a survey of 1,200 physicians on a scientific basis, that is a selection process, actually, and to do it through the telephone will again require several months.

Senator **Durenberger**. What is the time problem there? The scientific basis of selecting physicians?

Dr. **Hsiao**. It is a random selection of physicians; that is not selecting physicians based on their position in a community or their position in a specialty society, but rather based on a statistical random method, just selecting the practicing physicians in the field.

Senator **Durenberger**. If I had another 5 minutes, I would ask you 5 minutes' worth of questions, but I think you are getting my point.

Max.

Senator **Baucus**. Dr. Hsiao, I wonder if you could tell us a little more about the Canadian experience in trying to pay the same amount for the same service, the same procedure, in various geographical areas? What happened in Canada? When did Canada put this in place? What were some of the problems that Canadian physicians experienced?

I am just asking to what degree the Canadian experience can be applied, and what lessons can we learn from Canada that can be applied in our country?

Dr. **Hsiao**. Senator, the experience I refer to is the one in Quebec. When the Canadian Government in Quebec established a uniform fee that does not differentiate by rural or urban area, in Quebec, instead they pay one level of fee for all the physicians in that province.

They discovered that new physicians, particularly coming out of medical schools or new immigrants, then came to them and located their services or their practices in the rural communities or small communities.

Actually, statistically, we were able to find that there was a correlation between how that fee is structured and the redistribution of physicians in the Province of Quebec.

Senator **Baucus**. Are these Medicare payments?

Dr. **Hsiao**. These are the Canadian Medicare payments, but they have a nationalized system where there is only one payer, and that is the Government.

Senator **Baucus**. But still, it is a payment by the Government for—is that for all services?

Dr. **Hsiao**. For all services.

Senator BAUCUS. That is not only services for the elderly but also for others?

Dr. HSIAO. All the population.

Senator BAUCUS. Yes.

Since we have a different system, to what degree do you think we can apply that to our country?

Dr. HSIAO. I think, at least for the Government, for sound public policy, the Government should provide, as I say, a level playing field for physicians.

Right now, as Dr. Ginsburg also pointed out, there is an incentive, if not a distorted incentive, for physicians to locate in the high-fee areas, and that is in the urban areas and in the suburban areas. That is the historical charge-based system.

So, at least what we can do is to provide an equitable payment that will move away from the charge system.

Senator BAUCUS. What do you mean by equitable? By that do you mean that a charge should be the same for the same procedure, regardless of living costs in one area compared to another area, regardless of other costs that the physician may incur in one area as compared to another? Or are you saying that there should be some adjustment?

I am just wondering about the degree to which you would pay only the same amount for the same procedure, regardless of the other considerations.

Dr. HSIAO. Senator, in my written testimony I suggested that (1) there should be a study, and (2) we should recognize the differences in the cost between geographical regions, and also the cost of living for the physicians.

However, today the charge structure does not reflect these differences. For example, in New York City a physician charges often two times the charge in a rural community in the Midwest, and definitely New York City's cost of living or the wages is not two times that of these other communities.

Senator BAUCUS. You are suggesting that the charge of New York City and other urban area physicians is higher due to sort of a reverse supply and demand? That is; that in those areas where there are many physicians, the fact is that even though there are many sellers the price should fall. But because of the nature of the profession, the nature of the service provided, even though there are many sellers, for some reason the sellers seem to in kind of a monopolistic way get together and—not intending to do this, but it just works out this way—charge a higher price?

Dr. HSIAO. Yes. I don't mean there is collusion, but because there is a widespread insurance coverage, so the physicians can charge higher prices in the urban areas and get compensated. So, they can see fewer patients or do fewer surgical procedures but still maintain a certain income level.

Senator BAUCUS. Are you aware of any of the studies that are in progress, along the lines of the study that you are recommending—that is, to address the degree to which it makes sense to put in place a program that levels out the procedure charges? You said there should be a study; are you aware of any studies, or are you conducting any?

Dr. HSIAO. I am not aware of any study going on right now, but I am aware that the chairman and two other senators have proposed to mandate such a study, and I am in support of that.

Senator BAUCUS. Thank you.

Senator DURENBERGER. George Mitchell.

Senator MITCHELL. Thank you, Mr. Chairman. I apologize for being late; I had another meeting to attend. I do have a statement that I would ask be inserted in the record.

Senator DURENBERGER. It will be made part of the record.

Senator MITCHELL. Thank you, Mr. Chairman.

I would like to follow up on the line of questioning that Senator Baucus began and ask a couple of questions of both of you, and ask you both to respond.

First, I represent a State, as does Senator Baucus, which is rural in nature, and we are concerned about the fact that, under the current fee-for-service payment system, prevailing charges for the same service provided a specialist are often higher than the same service provided by a general practitioner. That would appear on its face to be unfair. It could, of course, ultimately in fact penalize rural areas, since many people in rural areas rely upon the services of a general practitioner and do not have access to a specialist.

Can you recommend a reimbursement mechanism which would not penalize the general practitioner who performs the same procedure as a specialist?

Dr. Ginsburg, why don't you go first, and then Dr. Hsiao?

Dr. GINSBURG. Sure. In general, the principle is that when the service is the same, the payment should be the same. I gather that for some procedures that is fairly clear; for others, such as the visits, there is concern that the nature of the service is different, that the specialist is bringing the additional training to that service and would warrant a higher fee in that respect.

Senator MITCHELL. But basically you agree that if the service is identical, it should be reimbursed at the same rate, regardless of the training of the person performing the service?

Dr. GINSBURG. Yes, that is correct. I believe that with some expert study, one could distinguish between those services where there is likely to be a difference and those where there is more confidence that they are similar.

Senator MITCHELL. Dr. Hsiao?

Dr. HSIAO. I certainly agree with Dr. Ginsburg, that if we can actually identify that two services are the same, or even just similar, then there is no reason to compensate one type of specialty higher than the other, or one lower than the other.

I think the technical question here is: Can we identify whether they are the same or similar?

Senator MITCHELL. Yes.

One of the problems that concerns me is the maldistribution of physicians in this country. In my home State of Maine, for example, there is a specific case with which I have been involved. A small town of Buxport, ME, has a regional health center, and they have been trying for over 2 years to recruit a physician—and there is a surplus in some of the urban areas. Can you suggest ways in which we could build into a new physician reimbursement system an incentive for physicians to locate in medically unserved areas?

That is suggested in the Medicare Physician Payment Reform Act. Do you have any suggestions along those lines, Dr. Ginsburg?

Dr. GINSBURG. I am concerned with singling out medically underserved areas, because of limitations with our ability to define them.

The general approach of dealing with urban/rural differences in payments will help along those lines.

I also would like to express optimism that some of the changes going on in the physician services market are likely to move in a direction of more service to underserved areas. What I have in mind is the increasing use of capitated plans and PPO's. This is bringing more of a semblance of a competitive market to the urban areas now; it is making it more difficult for physicians to maintain their high fee profiles in the urban areas and thus is going to make other areas relatively more attractive.

In addition, I feel that the Medicare participating physician concept is going to increase and the nature of competition in physician markets and, again, make it more difficult in areas with particularly high prices for physicians to maintain those prices.

So, some of the forces that Congress has set in motion and that have come about in the private sector are going to be working toward redressing this problem.

Dr. HSIAO. I think if a fee schedule or any kind of payment system is based on a resource-based cost, I think again you will see that would generate additional incentives and competition for physicians to relocate to the underserved areas.

On the other hand, in the short run, though, I think you can devise a bonus plan for the underserved communities; such as, you can allow *x*-percent additional payment for physicians who are serving in these underserved areas.

Senator MITCHELL. Thank you very much, Mr. Chairman.

Senator DURENBERGER. Thank you very much.

Senator MITCHELL. Thank you, gentlemen.

Senator DURENBERGER. Gentlemen, thank you very much. If you will, oblige us by just responding to a long series of written questions that we need to submit to you, we would appreciate it very much. Thank you for being here.

[The questions follow:]

[No response at press time.]

Senator DURENBERGER. Our next witness is Dr. Monroe Gilmour, secretary of the American Association of Retired Persons, from Charlotte, NC.

Monroe, we welcome you back once again. You have become one of the vital resources to this subcommittee, and we are grateful to you for taking the time to be here from North Carolina.

Your statement, which I have already alluded to in my opening remarks, will be made part of the record, and you may proceed now to summarize that statement.

STATEMENT OF MONROE GILMOUR, M.D., SECRETARY, AMERICAN ASSOCIATION OF RETIRED PERSONS, CHARLOTTE, NC

Dr. GILMOUR. Thank you very much, Mr. Chairman.

On behalf of the American Association of Retired Persons, I am grateful for the opportunity of being here and to testify to you on the subject of Medicare Physician Payment Reform.

As you heard, my name is Monroe Gilmour, secretary of the AARP and, myself, an internist in cardiology, retired 6 years ago after 40 years of practice.

The AARP is the Nation's largest organization of older citizens, representing 22 million persons, 50 years of age or over.

With me this morning is Chris McEntee, a very able representative of our legislative staff.

AARP commends you, Mr. Chairman, and your colleagues Senators Dole and Bentsen for introducing legislation to reform payment to physicians under Medicare. AARP agrees with you that the time has come to reform Medicare physician payment because, first, Medicare's current physician reimbursement system has caused overinflation in expenditures for physician services, has created numerous payment discrepancies, and has exposed beneficiaries to considerable financial risk.

Second, in addition, since physicians are the decisionmakers, rational and fair payment for their services is an essential prerequisite to an efficient health care system.

The Medicare Physician Payment Reform Act of 1986 is a good first step for restructuring Medicare physician payment policies. We are pleased that the sponsors addressed the problem of underpriced as well as overpriced procedures, and include further guidelines for the development of a relative value system.

However, AARP believes that the bill requires strengthening in order to achieve its intended goal. We are particularly concerned about the absence of beneficiary protection.

Both the authority to reduce overpriced procedures and the recalculation of the Medicare economic index will result in reduced Medicare payment for physician services. Unless such reductions are accompanied by some limitations on physicians' actual charges, the beneficiaries will end up paying even more of the cost of this gap or difference.

AARP also believes that the current freeze on both Medicare payments to physicians and on physicians' actual charges must be gradually phased out as reform is phased in. An abrupt end to the freeze would likely produce a rebound effect, whereby physician charges and beneficiary liabitity would skyrocket.

AARP is quite concerned about the discretion left to the Secretary to redefine the notion of inherent reasonableness.

AARP appreciates the difficulty of legislating in this area; however, as currently drafted, the bill permits the Secretary to ignore any or all of the specified factors.

AARP believes that the Secretary must be required to consider specific factors in determining reasonableness, including the impact on beneficiaries.

AARP strongly supports the creation of a relative value system. We believe that guidelines, in addition to an appropriate geographic adjustment, should be incorporated into the bill, including a better definition of the weighting system in order to correct current payment discrepancies. And we also believe that there should be a mechanism for regular recalibration of service definitions over a period of time.

Finally, AARP agrees with subjecting administrative payment changes to the procedures of the Administrative Procedure Act. While we prefer legislative reform to administrative reform, we strongly feel that appropriate public notice and comment is essential if administrative action in this area is undertaken.

I thank you, Mr. Chairman, and we look forward to working with you and your colleagues on this difficult and important issue. I will be happy to try to respond to any questions, with Chris McEntee's help.

Senator DURENBERGER. Thank you, Dr. Gilmour.

AARP supports a payment reduction for what are referred to, I think, in your statement as selected overpriced services. As you say in the statement, If part of the savings from those reductions can be reinvested, increased payments for so-called underpriced services.

Have you some idea as to which overpriced services you would recommend for reduction? And would you be able to identify by example some underpriced services?

Dr. GILMOUR. Well, we have not made a list of overpriced services, but I would say in general that the technological services are the ones that are overpriced, and the cognitive services are the ones that are underpriced.

Senator DURENBERGER. I would agree with that, I think in a general sense, and maybe, given your professional background, you can give us an example of that statement. I think that would be quite important.

My impression, for example, is that as a new technological innovation comes out, the costs of developing that are probably passed along and picked up from consumers in a year or maybe 2 years, something like that, and after that you would expect the prices to come down in a competitive market, but they never do.

In addition, malpractice laws and a variety of professional standards, I imagine, orient us toward using the latest technology and penalize us for using the little extra time for using what is between our ears.

Now, that is sort of my impression as a lay person who has been following this. I would like you to share with us your view as a practitioner of what has been going on out there.

Dr. GILMOUR. Well that agrees, really, with my impression as a practitioner. Having been, shall we say, a cognitive practitioner for a good many years, I have a certain bias in that direction. Taking care of a patient with a coronary, an attack, which is a very serious thing, where you have the responsibility of life and death, may consume a tremendous amount of time, not to mention emotional effort. And yet, sometimes for that patient nowadays—though, when I started there was no cardiac surgery available—the cardiac surgeon for a relatively brief but nevertheless a very important activity gets several times what I would get for several weeks of effort on the patient's behalf previously.

Senator DURENBERGER. I recall well a lunch I had a couple of years ago with one of the more well-known surgeons in the country who was an innovator right after the war in cardiac surgery. He sort of compared himself with the recent products of American medical schools. He said, "I was paid to sit down and think, and draw on my experience and my wisdom and my learning, and the realities, and think about this patient and what I knew about him, and all of that sort of thing, and then tried to get an answer to that, the best answer I could. But it seems to me some of these younger folks who have been coming out in the last 10 to 15 years are sort of doing it by the numbers, you know? The computer tells me this is the diagnosis, and then my training tells me, if that is the diagnosis, then I have to do A, B, C, D, E, F, something like that."

I think he left me with the impression that it was sort of a rote process, practically, rather than really drawing on some skill and experience.

What that says to me, obviously as a consumer, patient, is that I am sort of caught. I don't know how to make a judgment between a good surgeon and a not so good surgeon. My inclination is to go to the person who is more like Solomon than the person who is more like the go-by-the-numbers doctor. Has that sort of been your view of what has been going on?

Dr. GILMOUR. No; I really don't believe it is my view. I can't claim to be a recent product of a medical school——

[Laughter.]

Dr. GILMOUR [continuing]. But I feel that most surgeons do use a great deal of cognitive effort in their decisions, and I don't believe they do it by the numbers, as a rule.

Also, I will have to say that many surgeons get some great cognitive help from their medical consultants before they make their decisions.

Senator DURENBERGER. Does AARP support the provisions of S. 2368, which require hospitals to use the same coding system as doctors offices for part B changes?

Dr. GILMOUR. We feel that that would be a step in the right direction.

Senator DURENBERGER. Doctor, thank you very much.

Dr. GILMOUR. Thank you.

Senator DURENBERGER. George.

Senator MITCHELL. Do you think you can find any doctors who agree that they practice by the numbers?

Senator DURENBERGER. Probably not.

Senator MITCHELL. I just have one question, Dr. Gilmour. In your statement, on page 3, paragraph numbered 7, you suggest that the proposed legislation fails to protect beneficiaries against the rising cost of physician care, and weakens current incentives for participating physicians. Would you tell me, please, why you feel that way, particularly the part about weakening current incentives?

Dr. GILMOUR. Well, if the Medicare payment is going down, and a physician whose office feels already that the Medicare payment does not compensate him for not necessarily the cognitive services but for the expenses of his office, Medicare reimbursements going down further, then he is less likely, I believe, to take assignment.

Senator MITCHELL. But it is essentially a function of the amount of the reimbursement?

Dr. GILMOUR. I believe that is the reason.

Senator **Mitchell**. If you pay people more money, they are more likely to perform a service than if you pay them less?

Dr. **Gilmour**. No; I don't believe that many physicians think about the amount of money in connection with the service they perform. I do think that the running of an office these days is a rather difficult business for a physician who is not a businessman, and that if he feels he isn't being compensated adequately so that the service he renders will pay for itself at least, even if it doesn't make a profit, then he is less likely to take assignment.

Senator **Mitchell**. Really, I guess we are saying the same thing, but it is just that you are saying it more politely.

Dr. **Gilmour**. We are saying the same thing with different motivation.

Senator **Mitchell**. Right. Thank you, Doctor.

I have some more questions, Mr. Chairman, but I would like to submit them in writing.

Senator **Durenberger**. All right, thank you very much.

Thank you very much, Dr. Gilmour. We appreciate your testimony.

Dr. **Gilmour**. Thank you.

[The prepared statement of Dr. Gilmour follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

before the

SENATE COMMITTEE ON FINANCE

Subcommittee on Health

on

MEDICARE PHYSICIAN PAYMENT REFORM

April 25, 1986

Presented by:
Dr. Monroe Gilmour
AARP Board Member

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
Vita R. Ostrander *President* Cyril F. Brickfield *Executive Director*

Thank you, Mr. Chairman, for this opportunity to present the views of the American Association of Retired Persons (AARP) on Medicare physician payment reform. My name is Monroe Gilmour. I am Secretary of the Association and a retired cardiologist. AARP is the nation's largest membership organization of older citizens, representing 22 million older Americans.

I commend you and your committee for your leadership on this complex issue. AARP believes that Congress should begin now to bring about change in Medicare's current methods of paying physicians for the following reasons:

1. The establishment of the DRG system for Medicare hospital payment will continue to shift care provision from the inpatient to outpatient setting. If nothing is done to reform Part B, the move towards outpatient care will exacerbate Part B's current spending problems. Moreover, beneficiaries' out-of-pocket costs will significantly increase since coverage under Part B is much less comprehensive than coverage under Part A.

2. Even with the extension of the current freeze on Medicare payments to physicians, Medicare Part B expenditures will continue to rise at a significant rate, currently projected to be nearly 14% per year through 1988. This rapid rate of increase places pressure on the federal budget, leading policymakers to look for changes based upon program savings alone rather than ways to create efficiencies in Part B which would benefit both physicians and beneficiaries.

3. Physicians are the linchpin of the health care system. Their decisions influence utilization, and control an estimated 70% of total

health care spending. Health care inflation will remain unabated unless payments to physicians contain incentives for efficiency.

4. Medicare's current reimbursement system contains disincentives for the use of cognitive services such as diagnosis, history-taking and counseling, even though such services often better meet the chronic health needs of the elderly. Comprehensive reform, and eliminating these disincentives as part of that reform, would improve the quality of care provided to the older population.

5. The current system does not produce fair and rational fees and contains numerous payment discrepancies. Without reform to correct these problems, Medicare cannot become a prudent purchaser of physician services.

AARP believes that Congress should begin now to implement long-term reform in Medicare physician payment. Waiting for an ultimate solution such as capitation will merely prolong the debate and delay action which would improve Medicare physician payment for the future. My testimony today will address five areas:

1. current problems in Medicare physician payment;
2. beneficiary out-of-pocket liability for physician services;
3. short-term and long-term options for reforming Medicare's current method of paying physicians; and
4. AARP's views on the Administration's FY'87 budget proposals for Medicare physician payment.
5. AARP's views on the Medicare Physician Payment Reform Act of 1986.

Current Problems in Medicare Physician Payment

Total national expenditures for physician services totalled $76 billion in 1984 (an amount representing 20% of national health expenditures) and they have risen by 13% per year since 1971. Growth in Medicare expenditures for physician services has been even more rapid; between 1980 and 1984, such payments rose by 18% annually for a total expenditure of $14.6 billion.

Like the Hospital Insurance Trust Fund (HI or Medicare Part A), the Supplementary Medical Insurance Trust Fund (SMI or Medicare Part B) is heading for financial disaster. Part B is the fastest growing federal domestic program with expenditures projected to grow by nearly 14% per year through 1988. And while the general revenue financing to the SMI program protects it from insolvency, the rapid infusion of general revenues into the SMI program to meet rising expenditures strains the federal budget, further exacerbating the deficit.

While prices for physician services have been increasing at nearly twice the rate of general inflation, price alone cannot explain the rapid increase in Part B expenditures. Increasing "intensity of services", as measured by the number of services per enrollee, represents another important contributor to rising Part B costs. Between the 1980-1982 time period, increasing intensity accounted for nearly 40 percent of the growth in the Part B program. Any reform in payment policies will have to address not only price increases, but also volume increases.

Beneficiary overuse cannot be linked to increasing Part B expenditures. No study has ever demonstrated excessive or inappropriate use of medical services by the elderly. Each year only 60 percent of beneficiaries use reimbursed physician services. Moreover, the elderly's per capita visits to physicians have remained stable at about 6.5 visits per year since 1970.

It is now generally understood that Medicare's physician reimbursement system which is based upon what physicians customarily charge each year (the CPR methodology) encourages physicians to set higher prices and deliver more services, even though such prices and services may not be warranted in terms of costs and medical appropriateness. In addition, the CPR methodology has generated numerous discrepancies and anomalies in physician payment such as:

- The gap in compensation for the use of technology and procedures over cognitive services;
- Differentials in reimbursement by specialty, place of service, and geographic location;
- The presence of payment incentives that discourage the treatment of the sickest and frailest segments of the population;
- The presence of payment incentives that encourage the use of expensive hospital care over less costly office-based care.

Beneficiary Liability for Physician Services

While Medicare coverage for hospital services is fairly comprehensive, Medicare coverage for physician services (both in-hospital and out-of-hospital) is less than adequate. Under existing law, Medicare beneficiaries have substantial liability for the cost of physician services. Beneficiaries pay:

1. An annual Part B premium, which totals $186 in 1986 and has risen 116% since 1977;
2. An annual Part B deductible set currently at $75 which represents approximately $100 in actual out-of-pocket costs since only Medicare "allowable" charges count towards the deductible and the Medicare reduction rate (the amount by which actual charges are reduced by Medicare) is currently 24%;
3. Coinsurance equal to 20% of Medicare's "allowable" charges; beneficiary liability for Part B coinsurance more than doubled between 1980 and 1984; and
4. Charge reductions associated with unassigned physicians' claims which totalled $2.7 billion in 1984, representing a 100% increase since 1980.

As a result of these charge components, beneficiaries are now responsible for over 60 percent of total physician charges due under Part B.

Under current law a physician may accept or refuse assignment on a bill-by-bill basis. If the physician agrees to "accept assignment," he or she agrees to accept Medicare's reasonable charge determination (20% of which the patient must pay) as payment in full. If the physician refuses to accept assignment, the patient is liable for the same 20% plus the difference between Medicare's reasonable charge and the physician's actual charge.

Approximately 59% of all Part B claims submitted to Medicare for reimbursement at this time are "assigned" compared to less than 50% in 1977. AARP is pleased to note the increase in the assignment rate over the past several years, particularly since the enactment of the participating physician program. Nevertheless, beneficiary liability for "unassigned" claims has increased substantially over the same period, eroding the insurance protection available under Part B for the cost of physician care.

In the absence of comprehensive reform in physician payment, the Association approaches the issue of mandating Part B assignment with caution because of the risk of diminishing the current 59% physician assignment acceptance rate. The Association supports legislation that provides: (1) financial and administrative incentives such as streamlined billing to encourage physicians to accept assignment; (2) "participating" physician programs like those contained in the current Medicare physician fee freeze; (3) and the development of regional or local directories that identify physicians who accept assignment.

Public and private payments for physician services provided to Medicare beneficiaries now account for almost one-third of total physician expenditures; moreover, Medicare reimbursement to physicians represents on average nearly one-fourth of physician income. Mindful of these factors, the Association supports mandatory assignment but only as part of a more comprehensive payment system for physicians that establishes rational and fair reimbursement rates.

Medicare Physician Payment Reform Act of 1986

The Medicare Physician Payment Reform Act of 1986 purports to reform Medicare physician payment by clarifying the Administration's proposed regulations on inherent reasonableness and the Medicare economic index and by defining criteria for the establishment of a Medicare relative value scale. While AARP supports the goal of the legislation, AARP has serious reservations concerning the ability of this bill to achieve its intended goal. Rather than comprehensive restructuring of Medicare's physician payment policies, the bill perpetrates reform through piecemeal regulatory efforts. In addition, the legislation fails to protect beneficiaries against the rising cost of physician care and weakens current incentives for participating physicians.

Congress took an important first step towards addressing the complex problem of rising physician fees when it enacted the Medicare physician fee freeze. AARP believes that Congress should build upon this initiative and enact legislation which would serve as the basis for the institution of a more rational physician payment methodology. AARP believes that no one payment methodology (DRGs, fee schedules, capitation, etc.) will be appropriate for all types of physician services. Rather, a mix of payment mechanisms would better assure quality of care by preventing the placement of all providers under the same economic incentives.

Last year the Association commissioned Health Policy Alternatives, Inc. to study the issue of Medicare physician payment. I respectfully request the Chairman's permission to submit a copy of this study for the record. The report presents an assessment of the policies and practices used by Medicare to pay physicians for the services they provide to beneficiaries under the program and makes recommendations for restructuring Medicare physician payment. The Association supports the report's recommendation for the development of a national Medicare relative value scale. AARP believes that an RVS would improve Medicare physician payment by creating more predictable and rational payments than exist today. In addition, an RVS is a necessary prerequisite for determining fair compensation of any reform option such as capitation or other packaging arrangements. We also support the report's recommendation for incremental implementation of payment reform, both through use of a transition system and by allowing for correction of certain payment problems to take place over a period of time. Thus, reform could be accomplished without unduly sharp or unpredictable reductions or changes in payment levels that could disrupt the continuing availability of physicians' services to beneficiaries.

While long-term reform is phased in, AARP believes that the current freeze on both Medicare payments to physicians and physicians' actual charges must be gradually phased out. An abrupt end to the freeze would likely produce a rebound effect, whereby physician charges and beneficiary liability would skyrocket.

An analysis of the bill's sections follows.

o Sec.2 Procedures for the Establishment of Special Limits on Reasonableness of Charges

AARP appreciates the sponsors' intent to define the parameters around which the Secretary of Health and Human Services can redefine the inherent reasonableness of charges. However, this proposal does little to improve upon regulations proposed for comment on February 18, 1986, upon which AARP commented. By stating that the Secretary may, rather than shall, take into account certain factors, Sec.2 permits the Secretary to ignore specific factors necessary in determining reasonableness. The Secretary must be bound to consider all factors. In addition, uniform administration among carriers of any reasonable charge regulations is necessary in order to prevent further payment discrepancies among carriers.

More importantly, the language does not require the Secretary to consider beneficiary impact which could result from any reduction in overpriced services. Unless beneficiary protections are required, any attempt to reduce Medicare payment for a service will likely result in higher costs to beneficiaries.

o Sec.3 Development of Fee Schedule for Physicians' Services

AARP supports the creation of a Medicare Relative Value Scale (RVS) but believes that guidelines, in addition to an appropriate geographic adjustor as in this proposal, are necessary. Specifically, AARP urges adoption of the following guidelines for the development of the RVS:

1. The establishment of a nationally defined set of physician services.
2. The establishment of a weighting mechanism which considers

medical benefit in addition to cost of service and physician time and skill. In assigning weights particular attention should be given to correcting current payment discrepancies such as the gap in compensation between procedures and congnitive and primary care services.

3. The development of a measure of inflation which allows for reasonable payment increases in future years.
4. A mechanism for regular recalibration and reconsideration of service definitions, including a methodology to adjust payments as the cost of technology and services change over time.
5. A national decision on whether and to what extent medical specialty should affect the payment rate.
6. A mechanism for incremental implementation of assignment for all physician services once fair and reasonable payments are developed.

o Sec.5 Medicare Economic Index

Sec.5 allows the Secretary to adjust the Medicare economic index as proposed in the Administration's FY'87 budget but requires that the adjustment be phased-in over two years rather than one year.

Although this proposal would not lower Medicare payments as quickly as the Administration's proposal, the efffect is the same. The difference between the allowable charge and the actual charge which Medicare patients must pay if the physician does not accept assignment will increase. Such, lowering of Medicare payments discourages assignment and participation in in the program. If Congress wants to reduce Medicare physician payments, AARP believes that actual charges to beneficiaries must also be limited and that participating physicians should be exempted.

Second, the simple recalculation of the index ignores the acknowledged discrepancies which exist in the index and have been compounded over the 14 years of the index's use.

Lastly, for the administrative changes proposed in the bill, the Secretary is required to have a comment period of not less than 60 days and is required to respond to the comments when the final rule is published. It is our understanding that the Administrative Procedures Act already mandates such action for regulating initiative. We see no reason to restate current law in a new proposal. Such restating offers the public no further protection than currently exists today.

Short-Term Reform Options

AARP believes that it is essential for Congress to act now on long-term reform of Medicare Part B. AARP certainly recognizes the federal budget problem associated wth rapidly rising Part B expenditures. However, AARP believes that program savings alone cannot serve as the sole criterion for changes in Medicare Part B. Therefore, if Congress finds it necessary to implement interim measures to curtail Part B spending growth in FY'87, AARP recommends the following alternatives to a continuation of a flat fee freeze, alternatives which would not only produce savings, but also begin to redress current discrepancies and anomalies in Medicare physician payment:

1. A payment reduction for selected over-priced services with part of the savings reinvested to increase payments for under-priced services such as primary care services. AARP recognizes that many physicians continue to provide valuable primary care services and services which are cognitive in nature, even though current payment schemes penalize them for the use of these services rather than the use of procedure-oriented services. These options would produce budget savings by reducing reimbursement for those services which are overvalued. At the same time, reimbursement for services which have been undervalued over time would rise.
2. Safeguards against further cost-shifting to beneficiaries. A limitation on actual charges on non-assigned claims must accompany any reduction in Medicare payment for certain services. A reduction in Medicare payment for particular services would significantly widen the gap between allowable charges and physician actual charges. Without adequate safeguards against higher actual charges for those services, a reduction in Medicare payment would likely translate into higher costs by beneficiaries.
3. Improvements in the Participating Physician Program. AARP supports a strong participating physician program. The program represents a great improvement over past law in protecting beneficiaries against the rising costs of physician

care.

AARP is pleased that the 1985 Reconciliation Bill provided the fee increase to participating physicians as promised when the Medicare physician fee freeze began in July, 1984. In addition to fee differentials, AARP supports periodic interim payments and 100% reimbursement (with the carrier collecting the 20% coinsurance) for participating physicians. By improving cash flow to physicians, these measures would provide increased incentives to select the participating option.

The Administration's FY'87 Budget Proposals for Medicare Physician Payment

As part of its 1987 budget submission the Administration has proposed a series of administrative actions for the stated purpose of slowing down the rate of growth of expenditures for physicians' services under Part B of Medicare. While AARP supports the goal of redressing inequities in physician payment, AARP believes that legislative action, rather than administrative action, is the preferred approach to restructure Part B payment. A piecemeal, administrative approach would likely mean that the comparative adequacy of payment for different services would become more, rather than less, distorted.

Except for the regulatory proposal on inherent reasonableness, AARP has not seen any descriptions of the specific proposals other than those in the Administration's budget documents. We assume that the details of the other initiatives will be made available in the form of proposed regulations published for public comment. We do have some comments and concerns about the proposed actions based on what has been presented by the Administration in its FY'87 budget documents.

Medicare Economic Index

The Administration proposes to adjust the Medicare Economic Index to correct for an alleged overstatement of housing costs. AARP sees several problems with this proposal. First, as with many of the others which the Administration is making, this proposal would lower the amount that Medicare will accept as the allowable charge, increasing the difference between the allowable charge and the actual charge which Medicare patients must pay if the physician does not accept assignment. Moreover, the greater the difference between the allowable charge and the actual charges to patients in local markets, the more reason there is for physicians to avoid participation in the program or accept assignment. Second, it is not clear that a relationship exists between the costs of housing and the costs of office space for which it acts as a surrogate in the Medicare Economic Index. Third, the index has now been in use for more than 14 years without change. Since the index was constructed on rough averages of the relationship of certain practice costs in the various settings and in the various specialties in which physicians practice, the index has been--from the beginning--an inaccurate measure of the practice costs of those physicians whose actual situation was not near to the averages used. Fourth, the rates of increase for the various factors which make up the actual costs of practice have not been the same over the years among different geographical areas and among various specialties. The index, however, has been applied as though its effects were everywhere the same. Thus, the current Medicare allowable charge procedure contains an updating system which started with acknowledged imperfections and has experienced fourteen years of compounding the errors. We urge the Subcommittee to begin the admittedly difficult task of making revisions in the present system, not by a simple recalculation of the index but by including gradual revisions in the relative value system and the code of billable procedures which are fair and reasonable for all concerned. The intent of retroactively adjusting but one factor ignores the fundamental difficulties of using the index, except for the sole purpose of reducing arbitrarily the program's cost for physicians' services.

Reducing Over-priced Services

The Administration also proposes to control, which means "reduce", payments for certain physicians' services "that are over-priced" for selected reasons such as geographic variations or technological improvements presumably not recognized in the market place. The Administration has already moved in this area with a proposed regulation on February 18, 1986. AARP respectfully requests to submit comments on this proposed regulation for the record.

AARP does support the goal of redressing payment inequities in Part B. However, this proposal solely addresses over-priced services. AARP also believes that the current system produces under-payments for certain services, i.e. cognitive services. Since it is likely that some services are comparatively underpaid, the Association believes that adjustments in Medicare fee screens should address situations of both over-payment and under-payment.

In addition, the Administration's rationale for the changes is based primarily on the expected increase in costs of the Part B program. Analysis of the government's own actuarial reports shows that the primary cause of rising Part B expenditures is the increase in the utilization of services, not price increases. During the year ending June 30, 1985, the increase in the utilization of physician services was 3.0%, while the increase in physician fees recognized by Medicare as allowable charges was .7%. Yet the Administration's proposals are aimed almost exclusively at reducing allowable charges, and not at controlling continued increases in utilization. While we have no evidence about the extent of physician overutilization of Part B services, to the extent that it exists, it is doing possible physical and most certainly economic harm to Medicare patients. If effective efforts can be directed at the problem of overutilization, cost savings for the program can be achieved which might make more draconian measures unnecessary.

The Administration proposes also to reduce "excessive payments for lens replacement". We assume that the Administration will be issuing regulations under the authority of the provision regarding this matter in the Budget Reconciliation Act of 1985. We expect the Administration to require that only the acquisition costs of lens replacements should be allowed and that such costs should be identified separately from the professional services involved when the claim is processed. We would urge that the regulation be written so as to avoid increasing the financial burden on the patient. Similarly, in establishing stricter criteria of medical necessity for lens replacement we urge that the patient be protected from having to pay the bill if he or she has not been told that proposed surgery will not be covered. The nature of this surgery is usually such that decisions on medical necessity can be made in advance of the operation.

Stand-by Anesthesia and Assistants at Surgery

The Administration proposes to limit payments to stand-by anesthetists and assistants at surgery. This provision is also now part of the law for cataract surgery under the 1985 Reconciliation Act. Once again, we urge that in the implementation of such a regulation the interests of the beneficiary be protected.

The Administration also proposes to limit payment to stand-by anesthetists and assistants at surgery by regulation. The Reconciliation Act of 1985 includes a provision requiring the PROs or the carrier to approve in advance the use of assistants at surgery for excision of lens, commonly called a cataract operation. The law is silent on other surgical procedures.

We have been unable to obtain any indications on what policies the Administration intends to pursue for application to surgical procedures other than excision of lens. Nor have we been able to obtain data on the expenditures, frequency, and assignment rate for stand-by anesthesia and assistants at surgery. We expect, however, that the Administration will propose regulations for surgical procedures in addition to excision of lens.

We would urge that the Administration be required to consult with the Physician Payment Review Commission, established by the 1985 Reconciliation Act, and obtain its recommendations on these issues before promulgating proposed regulations on procedures in addition to excision of lens. The issues involved here quite obviously have to do with the practice of good medicine and the quality of the care provided to Medicare beneficiaries. Therefore, we believe that the input of professional advice into the policy process is required, particularly when the Administration has built for itself a record of putting cost savings above all other considerations.

Conclusion

Well-documented problems in Part B expenditure escalation and payment inequities illustrate that reform of Medicare Part B is long overdue. AARP looks forward to working with the Congress to establish a rational and fair method of physician reimbursement that would both encourage the delivery of cost-effective care by physicians and protect beneficiaries against ever increasing out-of-pocket medical expenses.

Senator **Durenberger**. Next we have a panel consisting of Dr. Jim Sammons, executive vice president of the American Medical Association, Chicago, IL; Dr. Bruce E. Spivey, executive vice president, American Academy of Opthalmology, San Francisco, CA; Dr. Franklin B. McKechnie, president of the American Society of Anesthesiologists, Winter Park, FL; and Dr. C. Rollins Hanlon, director of the American College of Surgeons.

Gentlemen, your full statements have been received and will be made part of the record of this hearing. You may now proceed to summarize them in 5 minutes or less, and we will begin with Dr. Sammons.

STATEMENT OF JAMES H. SAMMONS, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, CHICAGO, IL

Dr. **Sammons**. Thank you, Mr. Chairman, and members of the committee. It is a pleasure to be here with you again this morning.

I am Dr. James H. Sammons, the executive vice president of the American Medical Association, and with me this morning is Mr. Harry N. Peterson, who is the director of the AMA's Division of Legislative Activities.

Mr. Chairman, before I address some of the issues that are raised by the administration's fiscal year 1987 budget and the legislation developed by you, sir, along with Senators Dole and Bentsen, I have an obligation to my fellow physicians and the patients we treat to address the continuing Medicare physician fee freeze and reimbursement limitations.

Congress enacted the so-called temporary 15-month fee freeze and reimbursement limitations that were supposed to last only until October 1985. Instead, they were continued for all physicians for 22 months, until May 1 of this year, and for 30 months until at least the end of 1986 for nonparticipating physicians.

Now, this is clearly, in our view, sending a message to the Nation's physicians that Congress has no qualms whatsoever about abrogating its previous promises; even for certain physicians who had participated, unanticipated penalties have now been invoked against them.

The freeze and the limitations that are now scheduled to end on the first of the year should end, so that physicians will not be further disillusioned about Medicare. The credibility of Medicare should be restored, the confusion surrounding the program for patients and physicians ended. The charge freeze, unrelated to the budget, is highly discriminatory and should terminate.

Now, we appreciate the effort and the intent that the three of you, Senator Durenberger, Senator Dole, and Senator Bentsen, have made to intervene in the administration's proposed regulatory initiatives and to provide congressional direction. My personal view is that it is overdue, and I am delighted that the three of you have taken this tack.

Certain provisions of the bill, in our view, are very beneficial. There are others, however, that raise serious questions and would, in effect, legitimize questionable major regulatory actions of the administration, while major questions remain unanswered. These items are discussed in detail in my full statement and I won't repeat them all here.

But as far as the Medicare economic index is concerned, the administration's proposal calling for modification to the Medicare economic index [MEI] would in our view exacerbate the already adverse effects of the existing MEI.

The MEI has failed to serve as an accurate measure of inflation over the period 1976–86. The AMA strongly objects to the proposed retroactive formulation of an already inadequate index in such a way as to make it even more inequitable.

Now, while the proposed 2-year phase in of this modification and the proposed legislation represents an improvement, any retroactive application is inequitable. Retroactivity is intended to recoup a previous benefit. Not only would physicians in practice today be denied the full legitimate Medicare increases to recover their current increases in their expense, they would in effect have to repay so-called benefits received by physicians who practiced in prior years. In this treatment, physicians are again singled out for discrimination.

As to the HCFA common procedure coding, we support the recognition given for its use in Medicare and its application to hospital outpatient services. We are concerned, however, about the direction for simplification of the payment methodology because of the unknown but broad discretion that is given to the Secretary in that regard, and in our view that needs clarification.

Special limits on reasonable charges? HHS has proposed special reimbursement controls, using so-called inherent reasonableness authority. We do not believe that application of inherent reasonableness authority is the appropriate means for addressing high charges for medical services.

We are concerned that even the most careful drafting of legislation or regulations to implement such authority still will result in substantial gaps and even further inequities in coverage.

Mr. Chairman, we, too, are concerned with physician charges that do not accurately reflect the services provided. For this reason, the AMA is working with Harvard University on the development of a relative value study, as Dr. Hsiao has already pointed out to you, to establish a resource cost based relative value for physician services.

We are concerned that the present proposed statute would mandate this study to be finished before we believe adequate time will have elapsed for it to have occurred.

We also strongly believe that prior to any consideration of the inherent reasonableness, whether it be regulation or legislation, that the RVS must first be developed and carefully reviewed.

Mr. Chairman, I shall not continue, since the red light is on. Thank you very much.

[The prepared statement of Dr. Sammons follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Finance
United States Senate

Re: Physician Reimbursement under Medicare

Presented by: James H. Sammons, M.D.

April 25, 1986

Mr. Chairman and Members of the Subcommittee:

I am James H. Sammons, M.D. I am the Executive Vice President of the American Medical Association. Accompanying me is Harry N. Peterson, Director of AMA's Division of Legislative Activities.

The American Medical Association is pleased to have this opportunity to appear before this Subcommittee to address the subject of physician reimbursement under the Medicare program and the related issues raised in the proposal of Senators Dole, Durenberger and Bentsen. We testified before you last December on this subject, and we are pleased to update our views at this time. We continue to be seriously concerned over recent actions, both legislative and administrative, modifying physician reimbursement under Medicare. We are even more concerned over the potential future directions being considered and the implications for Medicare beneficiaries and their physicians.

FY87 BUDGET AND DOLE-DURENBERGER-BENTSEN PROPOSALS — PHYSICIAN REIMBURSEMENT

The Administration's FY87 budget contains numerous line-item proposals calling for modifications to the Medicare program through either legislative or regulatory action. The proposed bill addresses two of the Administration's regulatory initiatives, the development of an RVS, and the use of procedure coding.

Medicare Economic Index. The Administration's proposal calling for modification to the Medicare Economic Index (MEI) would exacerbate the already adverse effects of the existing MEI. As illustrated by the graph attached to this statement, the MEI has failed to serve as an accurate measure of inflation over the period of 1976 to today. Of greater relevance is the fact that it has also failed to accommodate the level of cost increase that the medical care community has faced, as measured by the rate of increase in the medical care component of the consumer price index (CPI).

If an inflation index is to be used in updating physician reimbursement levels, the index should accurately measure changes in the cost of providing health care services for Medicare beneficiaries. The MEI does not accomplish this. While a further modification to the MEI to recalculate housing costs (by taking into consideration rental costs) would be consistent with recent modifications to the CPI, the indicator still would fail to provide an accurate measure of the industry to which it is applied and would further exacerbate the problems of the MEI's failure to reflect accurately inflation in general and medical costs specifically.

We understand that consideration is being given to a retroactive application of the revised MEI so that any past housing component "imbalance" would be totally recouped. Such an application would result in a negligible increase (approximately 0.8%) in the prevailing charge level and would, in effect, continue the freeze on physician reimbursement for an additional year. This would be highly inequitable, especially in light of the fact that Medicare reimbursement for most physician services has not been increased since July 1, 1983. Moreover, the payment level set on that date was based on charges made in 1982. The AMA strongly objects to the reformulation of an already inadequate index in such a way as to make it even more inequitable.

The proposed two-year phase-in of this modification that is set forth in the proposed legislation represents an improvement. An expanded phase-in period in keeping with the overall timeframe of the MEI would be even more equitable. For example, if the MEI is reconfigured for the ten-year period of 1976 to 1986, the modifications similarly should be phased in over a ten-year period. However, in our view any retroactive application is inequitable. In theory, any retroactivity is intended to recoup a previous benefit. Physicians in practice today, however, would be denied full legitimate MEI increases to recover current expense increases. Moreover, current physicians would have to repay "benefits" received by physicians who practiced in prior years.

It would be inconsistent and arbitrary for physicians to be singled out for reimbursement reductions associated with cost index recalculations, as these technical revisions usually are applied to the future only. When the new housing definition was incorporated in a revised CPI as early as January 1983, cost-of-living increases for many workers and retirees were based on the new index only for subsequent years. No one whose paycheck or retirement benefit was tied to the CPI received an immediate retroactive adjustment or cut. If retroactive application is appropriate for physicians, similar application would be equitable for cost-of-living adjustments for federal retirees and social security beneficiaries. Any MEI change under Medicare should be applied prospectively.

The AMA supports the proposal in this bill that requires the publication with comment period of proposed changes in the MEI.

Special Limits on Reasonable Charges. The budget proposal calls for application of special reimbursement controls, using so-called "inherent reasonableness" authority. Prior to the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272 (commonly known as COBRA), the Secretary of HHS promulgated regulations to establish a methodology to apply "inherent reasonableness" criteria. We questioned both the authority and appropriateness of having the Secretary of HHS make determinations that were contrary to long-established methodology in the Medicare law. The regulations would even call for national limitations. John Wennberg, M.D., the recognized scholar studying the issue of medical care variations, points out (in his editorial published in the January 30, 1986 New England Journal of Medicine) that allowing reimbursement levels to be cut based on statistical norms could result in following the theory that the "least is always best" to fulfill the apparent governmental edict to save money.

The AMA recognizes that issues raised by geographic variations must be addressed. However, we agree with Dr. Wennberg that these issues must be approached from the viewpoint of assuring the availability of the best quality care, and not from the strict view of cost cutting. To this end, state medical societies have worked with Dr. Wennberg in the past, and the AMA currently is working with Dr. Wennberg and state medical societies in examining area variations.

The AMA shares your concerns that excessive charges should not be recognized by the Medicare program in determining the prevailing charge for a particular service. Nevertheless, we do not believe that application of "inherent reasonableness" authority is the appropriate means for addressing such issues. We are concerned that even the most careful drafting of legislation or regulations to implement such authority still will result in substantial gaps and even further inequities in coverage. While we understand that it is the intent of the proposed legislation to rectify the recently proposed regulations to establish the methodology to apply "inherent reasonableness" authority, we do not believe that the proposal accomplishes this. For example, while the AMA supports the proposal's recognition that regional differences in fees exist and are legitimate, the proposal does not preclude the Secretary's movement for national limits. The requirement for publication with comment period of any payment modifications made under "inherent reasonableness" authority, and the requirement for the Physician Payment Review Commission to comment on such proposals are commendable provisions and we support them.

The proposal lists six factors that the Secretary may consider in determining the application of "inherent reasonableness" limitations. While we believe that such factors are appropriate to consider when physician reimbursement questions are raised, we are concerned that this list fails to reflect the medical marketplace. The item relating to prevailing charges for a service in a particular locality being significantly in excess of or below prevailing charges in other comparable localities raises a series of questions:

- How are localities deemed "comparable?"
  - Are all standard metropolitan statistical areas to be deemed comparable?
  - Is one rural area to be deemed similar to another rural area?
- If comparable communities are found, how will the correct prevailing charge level be determined?
  - What will be the measure of excessiveness to determine that a charge is significantly in excess of or below whatever is the predetermined proper charge level?
  - Does the consideration of regional differences mean that national charge levels will not be set?
  - In a series of five charge levels for the same service, will the lowest one be deemed to be the correct one?
  - Would the highest charge ever be deemed to be the correct one?
- How will the system resolve the fact that individual physicians provide individually identifiable services for uniquely different patients?

Mr. Chairman, we are concerned that the legislation would allow the Secretary to continue to exercise unbridled authority in the application of "inherent reasonableness authority." Similar types of questions can be raised about other factors in the proposal:

- Where the Medicare and Medicaid programs are the sole or primary sources of payment for service, should the government be entitled to dictate the charge?
- If the marketplace for a service is not truly competitive because of a limited number of physicians providing that service, should the government pay a lower amount for that service and maintain this exclusivity; or should the government reimburse physicians at a rate equal to or higher than current billings to encourage others to enter that market?
- Where there are increases in charges for a service "that cannot be explained by inflation or technology," should the government lower the reimbursement regardless of other factors that may have led to the increase in charges?

Mr. Chairman, we, too, are concerned with physician charges that do not accurately reflect the services provided. For this reason, the AMA has taken a lead role in the development of a resource cost based relative value study (RVS) for physician services. Indeed, we believe that such a study would prove invaluable as a substantial step toward determining appropriate reimbursement for a particular service in a given locality. We strongly believe that prior to considering any "inherent reasonableness" limitations that it would be appropriate to first develop the RVS.

Relative Value Studies. The AMA is working with Harvard University on the development of a relative value study to establish resource cost based relative values for physician services. This study was recently funded by the Health Care Financing Administration. An indemnity reimbursement system based on a resource cost based relative value study could ameliorate many of the uncertainties inherent in current Medicare reimbursement. It would provide patients with a greater understanding of charges made for each service. It would also address inequities in payment rates for services that are inherent in the current method of reimbursement.

The proposed legislation would give specific recognition and more direction for the development of an RVS by the Secretary of HHS, as presently called for in COBRA. The proposed bill appropriately directs the Secretary to take into account cost differences based on geographic location. It also suggests that the government payment amount for physician services should be adjusted to assist in attracting and retaining physicians in medically underserved areas. However, we are very concerned with provisions directing the Secretary to develop an RVS without having the benefit of the results of the HCFA supported activity. Current law calls for the completion of the RVS by July 1, 1987 and the proposed bill calls for completion of an adjustment index by the same date. We recommend that the current law be amended to set this date back to at least allow the Secretary to consider the results of the Harvard study that is due to be completed by July 1, 1988. Such action is reasonable if the government is to benefit from its own funding of this study. Also, it is only reasonable that the medical community that would be affected directly by an RVS should have the first opportunity to analyze and develop it independent of the government.

HCFA Common Procedure Coding System - Development and Use

The proposed bill calls for the Secretary to "simplify the payment methodology" under the HCFA common procedure coding system to "ensure that such methodology minimizes the possibility of overstating the intensity or volume of services provided." The AMA has long urged adoption by HCFA of the use of Current Procedural Terminology, commonly known as CPT-4. HCFA has now adopted this for identification of physician services, and CPT-4 is embraced in HCFA's common procedure coding system. We support the mandate for continued use of CPT-4 by carriers and intermediaries. We also support the provision which requires hospital providers of outpatient services to adopt and utilize the CPT portion of HCFA's common procedure coding system.

The AMA does have serious questions concerning the intent to "simplify" the payment methodology under this system. Does this proposal call for the numbers of recognized procedures to be "collapsed?" If this is the case, there is a strong possibility that there could be over-reimbursement for some services with under-reimbursement for others. While there are a substantial number of codes that can be used to report physician services, there is justification for these codes. We strongly believe that it is the provider of the service who can best interpret the appropriate nature of the services and the intensity or volume of the services provided. The bill's mandate that the Secretary shall revise the "payment methodology" grants extremely broad authority. Does this proposal intend to have the Secretary arbitrarily assign a procedural code for physician services without regard to what the physician has indicated and without regard to the unique status that the individual patient brings into the care setting? Will the Secretary be able to "bundle" existing separately listed procedures? We sincerely hope this is not the case. We hope to be able to participate in further discussions on this proposal when it is being more fully developed. We cannot support this "simplification" without further clarification.

IMPACT - MEDICARE PAYMENT AND PHYSICIAN PARTICIPATION

Mr. Chairman, recent Congressional actions coupled with administrative actions could result in a loss of faith by physicians in the Medicare program. Recent modifications in the program have had the most deleterious effect on those physicians who have worked to hold the line on their charges and on physicians who expected Congressional promises to be fulfilled.

Those physicians who elected to participate in the AMA's voluntary fee freeze were penalized for their good faith efforts to hold the line on health care costs by the imposition of the reimbursement limits and fee freeze contained in the Deficit Reduction Act. Furthermore, in enacting these limitations, Congress intended them to last only until October of 1985. Instead, the freeze is being continued until at least the end of 1986 for those individual physicians who elect not to be listed as participating physicians. This serves to aggravate the disparity between income and expenses for physicians, lengthens the already substantial time lag in reflecting changes in Medicare reimbursement, and sends a clear message to the nation's physicians that Congress has no qualms about abrogating previous promises. The following items are illustrative of the constantly changing rules that physicians face in deciding whether to participate:

> Physicians who elected to participate in the first year of the program and decided not to continue this practice in the second year have had their charges rolled back to the level in effect for April, May and June of 1984 notwithstanding their belief that they would be able to increase their charges and maintain the increased charge level after October 1, 1985.

Physicians who elect participation status for the period beginning October 1, 1985 became subject to the Gramm-Rudman-Hollings limits that were established on Medicare reimbursement. This legislation acts to discourage physicians from accepting assignments.

With the lapsing (on March 14) of the Emergency Extension Act, Medicare carriers, under instructions from HHS, stopped making payments for physicians' services. While HCFA regional offices were told on April 3 to resume payments for physician services, the delay has been a penalty on those physicians who take assigned claims.

Physicians today are facing a new decision as to whether they should participate in the Medicare program. The legislation being considered today, as well as potential new regulatory actions of HHS, would impact on physician decisions to participate or not. Once again, physicians are asked to buy a pig in a poke. The recent track record of the government's treatment of participating physicians hardly recommends such status for individual physicians. Indeed, the recent actions point to an attitude taken by both the Congress and the Administration towards physicians that could well serve to discourage individuals from signing up as participating physicians.

Once made, decisions to participate or not cannot be modified regardless of future legislative or administrative acts that have a direct bearing on a physician's status. Since physicians are unable to modify their participation status, fairness and equity require that subsequent government changes in the terms of their agreement not be forced upon them. We recommend that legislation be adopted that would forestall any legislative or regulatory changes in physician reimbursement having the potential to modify a participation/non-participation decision. Physicians should not be penalized during or after the period of their decision.

NEED FOR LONG-RANGE ANALYSIS AND SOLUTIONS

Mr. Chairman, there can be no doubt that the Medicare program needs substantial modifications to avoid bankruptcy in the future. The "intermediate" assumption for the projected insolvency for the Medicare Hospital Insurance Trust Fund has been recalculated to advance from 1998 to as early as 1996. Clearly, Congress now should start addressing the long-range viability of the program.

The AMA has begun such an effort and issued two major reports on the Medicare program. The first report identified a series of proposals to help assure solvency of the program for the short-term. The second report sets forth a series of options that should be considered in any reform of the Medicare program. At the next meeting of the AMA's House of Delegates in June, a major report will be considered that will set forth a proposal to remedy the financing flaws of the Medicare program by providing health care for the elderly in a program assuring benefits for future generations. It is time to change funding of health care for the elderly from the current pay-as-you-go program to a system where resources will be set aside to provide real trust funds for the future. We believe that such a program could be workable. Mr. Chairman, after this report is considered by our House of Delegates, we will be pleased to share it with this Subcommittee and others.

ALTERNATIVE PHYSICIAN PAYMENT METHODOLOGIES

The attached appendix discusses alternative physician payment methodologies. The points discussed in this appendix were presented in our testimony before this Committee on December 6, 1985.

CONCLUSION

Mr. Chairman, we appreciate the effort and intent of the sponsors of the proposed legislation to intervene in the Administration's regulatory processes and to provide Congressional direction. Certain provisions of the bill are beneficial. Others, however, raise serious questions and would in effect legitimize questionable major regulatory thrusts of the Administration while major questions, as we have indicated in our statement, remain unanswered.

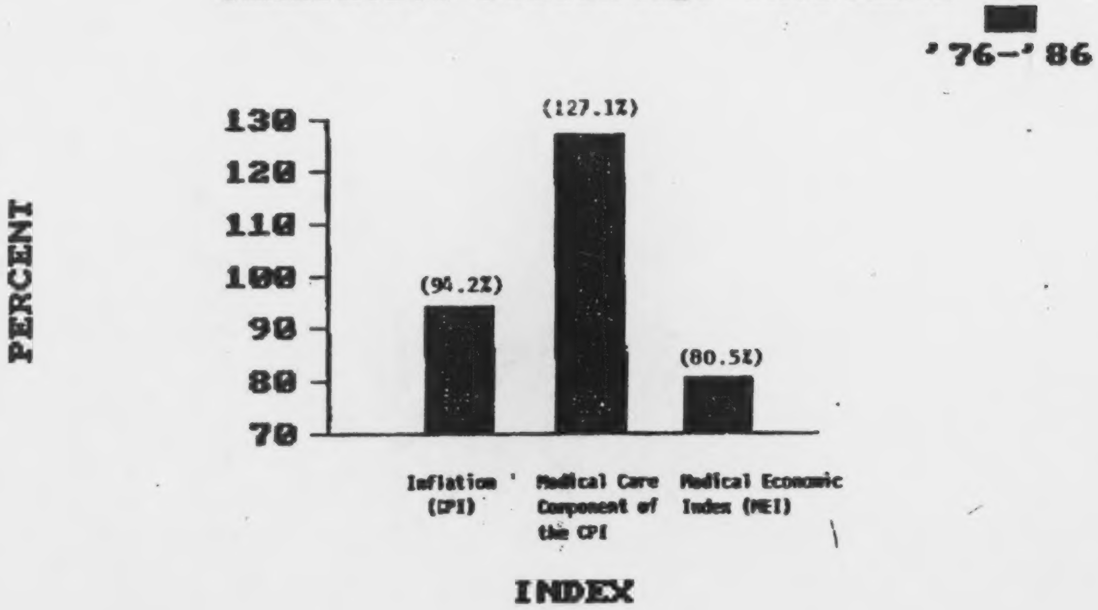
The AMA does not condone excessive charges for services. They should be rooted out from all government programs, whether physician specific, health related, or related to the purchase of hammers and screwdrivers by the Department of Defense. For years, we have sought Congressional authority so that the medical profession itself could aggressively address problems of excessive physician charges. The threat of catastrophic litigation must be removed so that physicians can perform the peer review that is desired and would benefit the public.

The regulatory and legislative proposals under consideration do not reach individual excessive charges. We are deeply concerned that a major spin-off of the new budget-directed activities will transfer additional costs to beneficiaries. Physicians have been and continue to be willing participants in the Medicare program. However, they are increasingly frustrated by a program that is in constant change where one cannot rely on program rules. Of special concern is the signal being sent to physicians that costs are of paramount concern. Actions taken to modify the reimbursement system for the many physicians who provide quality care to their Medicare patients should only be made on the basis of careful and thorough analysis.

We are continuing our review of this new legislation and will be pleased to work with the Committee in seeking equitable resolution to the vexing problems before the Committee.

We will be pleased to answer any questions the Committee may have.

Cumulative Percentage Increases



Prepared by: Center for Health Policy Research
American Medical Association

APPENDIX

ALTERNATIVE PHYSICIAN PAYMENT METHODOLOGIES

The AMA recognizes that changes in the Medicare program's physician reimbursement methodology may improve program administration and benefits for patients, those who provide services, and the federal government. We support research and demonstration projects to examine various methodologies for physician reimbursement. Such projects and studies are essential if there is to be a fair and successful modification in how physicians are paid for their services. Without adequate study, stop-gap quick fixes to perceived problems in the current methodology will be detrimental to the goals of providing health care services of high quality and continued improvement in overall health status for elderly and disabled patients.

In looking toward future modifications in the methodology of paying for physician services, there are a number of core questions that must be addressed in determining whether a proposed change in payment mechanisms will prove beneficial.

- Impact on access and quality -- Will the new payment system improve or reduce access and quality of care?
- Equity -- Will payment levels be set at an equitable level? How will they compare with other third party or private sector rates? Will the system recognize differentials in skills, risk, and severity of illness? Will the system contain protections to prevent windfalls to some and penalties to others?
- Value of services to society -- Will the payment system recognize the value of medical services as now reflected in the marketplace?
- Physician/patient relationship -- Will the payment system improve or interfere with the physician/patient relationship? Will it impose further federal intrusions into the practice of medicine?
- Societal concerns -- Will the payment system result in cost-shifting to non-elderly patients? Will all sectors of medical practice be treated fairly under the potential modifications?

The AMA fully supports a pluralistic approach to the payment for physician services. We believe that an indemnity payment system should be viewed as a preferred policy for setting physician reimbursement.

- American Medical Association -
Department of Federal Legislation, Division of Legislative Activities

Physician Payments Based on Diagnosis Related Groups (DRG)

One methodology for physician reimbursement being studied is to base payment on a fixed cost based on the patient's diagnosis. This concept is the focus of a Congressionally-mandated study by the Department of Health and Human Services that was due by July 1985 but has yet to be released.

Just as we have continuing concerns over the hospital DRG payment program, we have strong objections to a DRG-based physician payment plan. Even if such a plan were administratively feasible, we have grave questions over how it would affect the quality of care. A DRG system provides substantial incentives to limit care. The DRG methodology of payment also fails to take into account severity of illness. This would cause particular problems for those physicians who, because of specialized skill and training, see patients with the most severe illnesses. Since the DRG methodology is based on "averages" and individual physicians (unlike hospitals) do not ordinarily have a large enough patient population with identical diagnoses to enable costs to be spread over a larger base, a DRG system could operate as a disincentive for physicians to accept critically ill patients and could discourage necessary use of consultants.

We also oppose any program where physician services to hospital inpatients would be based on DRGs and payment would be made through the hospital. If both hospital and physician payments are based on a predetermined amount, all of the economic incentives will be strongly directed toward under-provision of care.

Perhaps the most serious drawback to a DRG-based payment system is that it could break down the role of the physician as the health care advocate for the patient. While physicians are concerned about costs, cost considerations should be secondary to the medical needs of the patient. We never want to see the day when the "best" physician would be viewed as one who was the most "efficient" as opposed to the one who provided the best individualized care. Because of its strong potential for adverse effects on patient care, we strongly object to a DRG system for physician reimbursement in the absence of demonstrations proving that the above concerns are unfounded.

Capitation - Vouchers

There has been a significant amount of discussion concerning capitation as the principal means of administering the Medicare program. Specifically, instead of the federal government providing payment for services (through carriers and intermediaries), a voucher would be issued by the federal government and each beneficiary would purchase his or her health insurance coverage in the private sector using the voucher as payment for all or part of the premium.

The AMA believes that there is merit to the voucher concept. In such a program competition would operate to respond to the needs of the patient population. Heavy federal regulation would not be necessary to direct every aspect of the program, as there would be natural incentives for economy. Beneficiaries would also benefit from the increased freedom to choose a health benefit plan that meets their individual needs and allows them to accept increased responsibility for their health care choices. Research should be conducted on the feasibility and appropriateness of this approach for the Medicare population before any widespread application.

Geographic Capitation - Another approach to capitation would involve the federal government giving one entity the entire responsibility for providing services for all beneficiaries in an area.

This so-called geographic capitation raises numerous concerns, especially relating to the effect on competition and market power of the contractor. While such an approach may offer benefits in theory, we believe that any program change of such magnitude should be studied through demonstrations in a number of areas. It must also be recognized that such demonstrations have the potential of substantial drawbacks if they are allowed to create substantial modifications in the health care infrastructure in the area where they are imposed. For this reason, we recommend that geographic or regional capitation demonstrations look closely at the impact of the program on a limited number of beneficiaries. For example, a demonstration program where a portion of the beneficiaries are placed in the capitated system would allow for an effective demonstration while at the same time lessening the potential for major harm to the health care system if the program proves to be unacceptable.

For the past two years, all Medicare beneficiaries have been the unwilling subjects of an untested DRG system; serious questions are now being raised concerning adverse effects on quality of care. Congress should not again experiment on the entire Medicare population or even on entire geographic areas. Instead, we urge the Subcommittee to require adequate, limited demonstrations of any capitation concept to determine what effect it will have on patient care.

Senator **DURENBERGER**. Thank you, Dr. Sammons.
Dr. Spivey.

STATEMENT OF BRUCE E. SPIVEY, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF OPHTHALMOLOGY, SAN FRANCISCO, CA

Dr. **SPIVEY**. Good morning. My name is Bruce Spivey. I am a practicing ophthalmologist from San Francisco and executive vice president of the American Academy of Ophthalmology.

Today I am representing 13,500 physicians, members of the academy, over 90 percent of those who treat medical and surgical conditions of the eye.

As I think you know, the administration has targeted cataract surgery as one of a small number of procedures which will bear a significant portion of the fiscal year 1987 budget cuts under part B of Medicare.

We believe that singling out of cataract surgery for a reduction in the surgeon's fee is unfair, and that the potential reduced access to physician anesthesia services will adversely affect the quality of patient care.

Over the past 3 years, ophthalmology has experienced major shifts in cataract surgery practice patterns, stimulated by Medicare budget cuts. We have experienced pressure by State PRO organizations and hospitals under the DRG system to overnight shift cataract surgery into the outpatient setting. We have experienced intense scrutiny over the cost and reimbursement method for intraocular lenses. We have experienced the denial of assistants at surgery for cataracts, and now we will be experiencing the COBRA requirement for 100 percent presurgery review by the PRO. We certainly have had a lot of experiences.

We are particularly concerned out of those, however, that the sanctions involved in the denial of an assistant surgeon during cataract surgery may deny patients the best of care.

The President's fiscal year 1987 budget again takes aim at cataract surgery, first by suggesting that the anesthesiology services be reduced, and second, the singling out of the ophthalmologist's fees for special reductions.

The academy strongly urges the continuation of access to physician anesthesia services during cataract surgery. The provision of anesthesia is a delicate medical decision that has life-threatening consequences to the patient. The ophthalmic surgeon and his assistant must concentrate on a microscopic view of the operative eye and cannot sufficiently monitor the patient's vital signs or the intravenous medication.

Elderly patients require appropriate anesthesia care before, during, and after surgery. We urge this committee to prevent the administration from using budgetary benchmarks to seriously affect the safe and successful outcome of cataract surgery and even the patient's life.

Next, the academy recognizes the inequities which have arisen over the years in Medicare's customary prevailing and regional charge system of physician payment, but the solution is not to single out two or three procedures this year and then next year pick another three or four, as the administration has proposed. The end result may be greater inequities than the present system and even more perverse incentives.

We understand that HCFA has a budget target of $100 million to cut from physician fees for three so-called overpriced procedures. We believe that such monetary targets are arbitrary and unfair. We believe that long-term savings would be greater and more equitable if a rational physician-wide payment reform system was instituted.

We have cooperated with other medical organizations and HCFA in initial discussion on wide-ranging reforms and will continue to do so.

Cataract surgery fees have been targeted by HCFA to meet a significant portion of the physician payment reform reductions because of the volume of cases, not because there is any conclusive data on overcharging by the average ophthalmologist.

There is a general mistaken impression that new technology has made cataract surgery easier and quicker, or that the technology is doing the surgeon's work. I believe the opposite to be true. Today's cataract surgery is far more complex and requires a far greater level of skill in the surgery than that of 15, 10, or even 5 years ago.

In order to achieve the high quality results of which we are so proud, far more complex and delicate maneuvers are required by the surgeon than in the past. In other words, ophthalmologists have achieved the high success rate in cataract surgery by mastery of greater technical skills. That is why we object to being singled out and penalized for this accomplishment.

We recognize, however, the momentum to control and reduce Medicare costs. If this committee cannot prevent the administration from cutting cataract surgery fees, then we hope that you will insist on an equitable approach to cost containment. Please do not put the burden on those ophthalmologists who have voluntarily kept their fees at a reasonable level and who have conducted their practices in an ethical manner.

Thank you.

[The prepared statement of Dr. Spivey follows:]

American Academy of Ophthalmology
Testimony on
Medicare Physician Payment and Cataract Surgery
Before the Senate Committee on Finance
Subcommittee on Health
April 25, 1986

My name is Bruce E. Spivey, MD. I am a practicing ophthalmologist from San Francisco, California, and Executive Vice President of the American Academy of Ophthalmology. I am appearing on behalf of the Academy, representing more than 13,500 or 90 percent of the physicians who specialize in medical and surgical treatment of the eye. We appreciate the opportunity to present the Academy's views on Medicare physician reimbursement and cataract surgery.

As you know, the Administration has targeted cataract surgery fees as one of three procedures which will bear a significant portion of the FY 1987 budget cuts under Part B of Medicare. We object to the singling out of cataract surgery, and urge the Committee instead to turn its attention to more rational reforms which may offer long range savings.

We appreciate that the proposed Dole-Durenberger-Bentsen bill is more sensitive to regional differences, and would require a more concerted effort by the Administration in establishing "reasonable" fees. Our analysis of the specifics appears on page 12.

Mr. Chairman, we wish to emphasize that we take seriously the physician's responsibility as an advocate for the patient. We are here today to express our concern that efforts to reduce Medicare's budget could have serious negative effects on our senior citizens' health status. We urge that quality of care be this Committee's guiding light, not arbitrary budgetary goals.

Trends in Cataract Surgery. The Committee knows how important adequate vision is in maintaining the independence of our senior citizens. Cataracts are a major cause of impaired vision and blindness among the elderly, with an 18 percent prevalence among the 65 to 74 age group, and 45.9 percent prevalence among the 75 to 85 age group. [1] Fortunately, eyesight can be restored in the majority of cataract cases through highly successful modern cataract extraction procedures. The implantation of a prosthetic intraocular lens provides superior rehabilitation, often resulting in near normal vision.

In the last five years, cataract surgery has undergone tremendous strides in improved surgical technique, as well as important refinements in the intraocular lens. Ophthalmologists have worked hard to bring their skill levels up to the standards needed to operate the advanced technology associated with the state-of-the-art in cataract extraction and IOL implantation. This has greatly increased the success rate of the surgery and decreased the risk of post-operative complications.

Cataract surgery's success has resulted in a significant growth in the number of operations nationally, drawing the interest of federal policymakers. Early statistics from the new DRG/prospective payment system showed cataract surgery to be one of the ten most frequently performed procedures under Medicare. Most state Peer Review Organizations targeted cataract surgery as a preliminary goal to reduce inpatient admissions. The pressure from PROs, and from hospitals who viewed the DRG price for inpatient cataract surgery as too low, speeded up a nationwide shift, turning cataract surgery into an exclusively outpatient procedure in less than a year.

Payment for Intraocular Lenses. Last summer, two additional aspects of cataract surgery came under scrutiny: (1) the cost and reimbursement policies relating to the supply of IOLs; and (2) the variation in use of assistants-at-surgery. Regarding IOL reimbursement, for some time, the Academy had recommended that the Health Care Financing Administration adopt a uniform reimbursement methodology that covered the IOL cost plus handling. If this had been implemented when the issue first arose, much of the effort and expense to the Medicare program might have been saved.

Denial of Assistants-at-Surgery. Regarding assistants-at-surgery, the Inspector General conducted a survey which apparently revealed a variation from carrier to carrier in the utilization rate of a second surgeon during cataract surgery. The Inspector General asked the Academy for our comments on this study. We objected to the conclusion that assistants-at-surgery should be denied payment across the country because some carriers did not reimburse for it. We strongly urged the continuation of the primary surgeon's choice of assistant, recognizing that the best choice would be another ophthalmologist.

Over the Academy's objections, HCFA instituted strict Medicare carrier screens which resulted in defacto denial of assistants-at-surgery. Also, Congress enacted provisions in the consolidated Omnibus Budget Reconciliation Act (COBRA) mandating state PRO review of requests for the second surgeon prior to cataract surgery. In some areas, this policy has dramatically changed the practice of medicine. For those ophthalmologists who have traditionally depended on a second surgeon, this new policy is viewed as an inappropriate incursion of government into the fundamental medical decisions made by the surgeon, which could adversely affect the successful outcome of particular cataract surgeries.

The Academy is also concerned with the harsh sanctions in the new statute. COBRA stipulates that once the PRO has denied coverage for the assistant, neither the primary surgeon nor the second surgeon may bill the patient, under stiff penalties. First, it is unclear why such penalties are needed, or how they would be enforced. Secondly, they leave the patient with no choice, even if freely willing and able to pay for a second surgeon. We believe that the sanctions should be rewritten, and will provide the Committee with draft language.

PRO Review of All Cataract Surgery. COBRA also requires state PROs to perform 100 percent review of ten Medicare covered surgical procedures to reduce their utilization. Cataract surgery was suggested by the House Energy and Commerce Health Subcommittee Chairman as one of the ten procedures for PROs to target. The Academy has grave concerns over this total review requirement.

First, there is no medical treatment alternative for cataracts. Once it has been established that the patient has a cataract, surgery is the only method to correct the problem. The issue then becomes the timing of the surgery. This decision is very subjective, and best made on a case-by-case basis, by the surgeon and an informed patient.

Second, we are very concerned that the motivation behind 100 percent utilization review is monetary, not quality of care. The delay or denial of elective surgery may provide short term savings for the Medicare program; however, in the case of cataract surgery, it may only put off expenditures until the next fiscal year.

In order to monitor cataract surgery for quality of care issues, the PRO might establish review guidelines which follow the patient after surgery. The Academy's Code of Ethics provides direction on the appropriate post-operative care of cataract patients. We would support PRO efforts to monitor suspected itinerate surgery, abandonment of patients, and premature referral of patients to non-physicians.

Third, the 100 percent PRO review is an added paperwork burden on the surgeon, and an impediment to the scheduling of surgery according to the patient's and his or her family's convenience. This is a particular problem for the elderly patient in rural areas, who may be required to travel some distance to the hospital, especially since the cataract surgery is usually performed on an outpatient basis.

FY 1987 Budget. Over the last three years, cataract surgery has experienced major shifts in practice patterns as a result of federal efforts to tighten the Medicare program's fiscal belt. The President's FY 1987 budget again takes aim at cataract surgery, by (1) suggesting that anesthesiology services be reduced, and (2) by singling out ophthalmologists' fees for special reductions.

Anesthesiology Services. The Academy strongly urges the continuation of access to physician anesthesia services during cataract surgery. The ophthalmic surgeon and his assistant must concentrate on a microscopic view of the operative eye and cannot sufficiently monitor the patient's vital signs or the intravenous medication.

Many cataract patients in their sixties and seventies have cardiovascular and other medical conditions which increase their risk under anesthesia. These patients require appropriate anesthesia-related care just before entering the operating room, during the surgery, and in the recovery room. We urge this Committee to prevent the Administration from using budgetary benchmarks to cut into medical practice decisions regarding the level of anesthesia services which could seriously affect the successful outcome of cataract surgery. [The Academy's position is detailed in the attached letter to the Health Care Financing Administration.]

Physician Reimbursement Reform. We acknowledge the government's role in controlling Medicare expenditures and ensuring that medical care is provided as efficiently and economically as possible. However, we have serious concerns over the FY 1987 budget proposals to implement piecemeal cuts through agency action, rather than to provide for a rational, equitable, statutory reform in the method of reimbursing physicians.

There are a number of attempts currently underway to provide a comprehensive view of the subject. One is the Administration's report to Congress on physician payment reform, which is long overdue. Another is HCFA's commitment of federal grant funds to a Harvard University project that would look at the feasibility of a relative value scale for physicians. This is in its early stages. COBRA establishes a Physician Payment Review Commission which is charged with recommending physician reimbursement reform. COBRA also requires the Department of Health and Human Services to develop a relative value scale for physician payment under Medicare and Medicaid.

The Academy recognizes the inequities which have arisen over the years in Medicare's reasonable, usual, customary and prevailing charge system of physician payment. But the solution is not to single out two or three procedures this year, and then next year, pick another three or four. The end result will be greater inequities in the current system, and possible perverse incentives for physicians to discontinue the use of the safer, more successful procedures.

During the last two years, physicians fees have been frozen under Medicare, despite continuing cost of living, wages, rent and other overhead increases. Add to this, the burden on a physician's practice for the amount of claims which have been lost, mis-coded, or incorrectly paid, and the processing slow-downs by the Medicare insurance carriers. The carriers were ill-equipped to simultaneously implement the freeze, the participation requirements, a dramatic new "uniform" coding system, and new medical screens aimed at denying payment for a host of medical and surgical procedures and supplies.

$100 Million in Cuts for Three Procedures. We understand the problem: the President has given HCFA a budget target of $100 million to cut from physician fees for three "overpriced" procedures. We believe that such targets are arbitrary and unfair. We believe that long term savings would be greater and more equitable if a rational, physician-wide payment reform system was instituted. We have cooperated with other medical organizations and HCFA in initial discussions on wide-ranging reforms and will continue to do so.

Cataract surgery fees have been targeted by HCFA to meet a significant portion of the President's physician payment reductions because of the volume of cases, not because there is any conclusive data of "overcharging" by the average ophthalmologist. First, the "uniform" codes for Part B services are still in the implementation process, with "bugs" to work out. So there is little if any readily available national data on physician fees. Second, there is no standard by which to judge the relative value of cataract surgery fees compared to other surgical procedures.

Third, there is a general mistaken impression that new technology has made cataract surgery easier and quicker, and/or that the technology is doing the surgeon's work. The opposite is true. Today's cataract surgery is far more complex, and requires a far greater level of skill than surgery of five, ten or fifteen years ago. In order to achieve the high quality results of which we are so proud, the surgeon must take extra care in the incision, removal of tissue, constant irrigation of the organ, and insertion of the IOL.

Cataract extraction is still performed with a knife, not with a laser. It is often performed under a local anesthetic, where the patient is aware of the conversation and activity in the operating room, although unable to see. This requires greater concentration and discipline among the surgical team. Because it is almost exclusively an outpatient procedure, the ophthalmologist is much more involved in the patient's basic preparation for surgery, than when performed as an inpatient where various diagnostic, administrative and other details were routinely handled by the hospital staff.

In other words, ophthalmologists have achieved the high success rate in cataract surgery by expending a greater personal effort. That is why we object to being singled out and penalized for this accomplishment.

Senate Proposal. We recognize, however, the momentum to control and reduce Medicare costs. If this Committee cannot prevent the Administration from cutting cataract surgery fees, then we hope that you will insist on an equitable approach to cost containment. Please do not put the burden on ophthalmologists who have voluntarily kept their fees at a reasonable level and who have conducted their practices in an ethical manner.

The Dole-Durenberger-Bentsen proposal recognizes regional variations which we would probably prefer over a single national fee. It also recognizes market forces, such as the competition among providers. In recent years, we have seen an increase in the supply and distribution of ophthalmologists. There is strong evidence of a highly competitive market in cataract surgery.

We approve of the bill's requirement that HHS provide at least sixty days notice of changes. As you know, HHS has issued many of its key regulations affecting the prospective payment system, physician reimbursement, and other Medicare program changes with less than a sixty-day comment period.

We oppose the bill's thrust of allowing HHS to target certain procedures for an increase or decrease in payment based on the "inherent reasonableness" of fees. This piecemeal approach is likely to add greater inequities to the system. We would prefer that the government's resources be used to develop an overall, rational reform of the physician payment system, not to spend time trying to justify cuts in "popular" procedures such as cataract surgery.

We approve of the bill's intent that uniform coding be established for outpatient hospital services, and that improvements be made in the current procedure coding. However, it has been our experience that recent problems have centered around the local insurance carriers ineffectiveness at implementing the new codes, not on the coding system itself. We would caution against specific statutory language on this subject, especially since the current codes used by hospitals under the DRG system are not compatible with the HCPCS/CPT system.

Instead, we would like to see closer monitoring of the carriers by the General Accounting Office, or some other independent auditor. This might improve efficiency and alleviate many of the complaints we have received from our members relating to claims processing, coding, payment, etc. Secondly, the Committee might require specific data collection activities on outpatient hospital services. HHS does not seem to have an adequate database for outpatient hospital services.

Thank you for the opportunity to appear before the Committee today. I will be happy to address your questions.

[Footnote [1] from page 2: Kahn, H.A., Leibowitz, H.M., Ganley, J.P., et al: The Framingham Eye Study: I. Outline and Major Prevalence Findings. American Journal of Epidemiology 106:17-32, 1977, in Vision Research: A National Plan 1983-1987. Report of the Cataract Panel. U.S. Department of Health and Human Services, National Institute of Health, 1983, p. 1.]

AMERICAN ACADEMY OF OPHTHALMOLOGY

SECRETARIAT FOR
GOVERNMENTAL RELATIONS

Robert D. Reinecke, MD
Secretary
Wills Eye Hospital
Ninth and Walnut Streets
Philadelphia, PA 19107

James V. Aquavella, MD
Associate Secretary for
Health Plans
919 Westfall Road
Rochester, NY 14618-2699

Thomas Frey, MD
Associate Secretary for
Federal Legislation
6231 Leesburg Pike
Falls Church, VA 22044

Michael A. Lemp, MD
Associate Secretary for
Research and Regulatory Agencies
c/o Dept. of Ophthalmology
Georgetown University Med. School
3800 Reservoir Rd. N.W.
Washington, DC 20007

Richard S. Ruiz, MD
Associate Secretary for
Federal Systems
1203 Ross Sterling Avenue
Houston, TX 77030

Hunter R. Stokes, MD
Associate Secretary for
State Affairs
P.O. Box F-17
602 E. Cheves St.
Florence, SC 29501

OFFICE OF
GOVERNMENTAL RELATIONS

Cynthia C. Root
Director
1101 Vermont Ave., N.W.
Suite 300
Washington, D.C. 20005-3570
(202) 737-6662

March 10, 1986

Henry Desmarias, M.D.
Acting Administrator
Health Care Financing Administration
Room 314G-HHH Bldg.
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Anesthesia Services During Cataract Surgery

The American Academy of Ophthalmology, with a membership of 13,500, representing 90 percent of the ophthalmologists in the U.S. affirms the need for continued Medicare coverage for anesthesiology services during cataract surgery.

As you know, cataract surgery has evolved in recent years to a highly successful procedure which may be performed on an outpatient basis. Nearly 90 percent of cataract patients will receive an intraocular lens - a prosthetic lens usually implanted at the same time the clouded natural lens is removed. A typical cataract operation requires up to an hour and a half of operating room time. Most cases involve intravenous medication and are performed using a local anesthesia block to immobilize and anesthetize the eye, and a second local anesthesia which anesthetizes the skin and tissue around the eye to minimize facial pain. A significant percentage of cases requires the use of inhalation anesthesia.

Eighty-five percent of all cataract operations in the United States are performed on Medicare eligible patients. In this age group, existing medical conditions (hypertension, diabetes mellitus, arteriosclerotic cardio-vascular disease) could become medical emergencies during surgery (cardiac arrhythmias, hypotension, respiratory or cardiac arrest), and the availability of maximally effective anesthesia personnel is essential. We feel that the best representative of this level of care is a medical doctor.

Cataract surgery is a complex microsurgical procedure involving highly specialized and finely calibrated instruments and techniques. The surgeon and his or her surgical assistants must devote their full attention to the single operative eye, often through an operating microscope. Hence, the surgeon and surgical assistants are virtually isolated to a microscopic view of the eye only and depend on other specialists to continually monitor the patient's vital signs and level of anesthesia, give intravenous medication, and to provide oxygen or other services necessary to relieve pain and anxiety and/or to resuscitate a patient experiencing respiratory or cardiac distress during the surgery. While life threatening emergencies may occur in 3-5 percent of cataract procedures under local anesthesia, because of the volume of cases - one million predicted in 1986 - the incidence could potentially involve 30,000 or more senior citizens.

Often the anesthesiologist administers a sufficient level of drugs to suppress the patient's sensation while the local anesthetic is injected in the orbit around the eye. The local anesthetics commonly utilized have one particularly significant complfcation, respiratory arrest, even among patients who are young and healthy. In such instances, an anesthesiologist present during administration of the local anesthetic maintains the patient's respiration by means of artificial support while administering medication to alleviate the respiratory arrest. Regardless of who administers the anesthesia, or whether a local or general anesthesia is used, personnel trained in anesthesia administration, patient monitoring and resuscitation must be in the operating room for the duration of the cataract surgery, both with local and general anesthesia.

The members of the anesthesia team should be selected with the concurrence of the surgeon. A medical doctor specializing in anesthesiology is the preferred specialist to care for the patient or to supervise the anesthesia care during cataract surgery. An anesthesiologist practices direct patient care. Thus, apart from the technical skills in administering anesthesia, the anesthesiologist functions as a diagnostician, pharmacologist and physiologist.

Under TEFRA regulations, an anesthesiologist will receive Medicare Part B reimbursement if the following services are provided to the patient:

(1) perform a pre-anesthetic examination and evaluation;
(2) prescribe the anesthesia plan;
(3) personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence;
(4) ensure that any procedures in the anesthesia plan that he or she does not

perform are performed by a qualified individual;

(5) monitor the course of anesthesia administration at frequent intervals;

(6) remain physically present and available for immediate diagnosis and treatment of emergencies;

(7) provide indicated post-anesthesia care; and

(8) either perform the procedure directly, without the assistance of a Certified Registered Nurse Anesthetist (CRNA) or direct no more than four anesthesia procedures concurrently and not perform any other services while directing concurrent procedures. (Source: American Society of Anesthesiologists, paper for the Office of Technology Assessment, 5/10/85.)

If an anesthesiologist meets the above regulatory requirements during cataract surgery, then Medicare should continue to permit separate appropriate reimbursement for the anesthesiologist's services.

Separate reimbursement for anesthesia services is necessary because there is generally little correlation between a given surgical procedure and the anesthesia management provided in connection with such surgery. There are variations in the patient's anxiety level, medical difficulties, risks, conversion to general anesthesia and other factors vital to the anesthesia problem which are unrelated to the surgical problem, and unpredictable. Thus a "packaging" approach to physicians fees (surgeon and anesthesiologist) relating to specific surgical cases is inappropriate.

In summary, the American Academy of Ophthalmology strongly recommends continued separate coverage under Medicare for services provided by anesthesiologists during any or all cases of cataract surgery. The choice of anesthesia personnel available to care for the patient during cataract surgery must be maintained, regardless of the type of anesthesia used, or the setting in which the surgery is performed.

Sincerely,

Hunter Stokes

Hunter Stokes, MD

Senator **Durenberger**. Thank you very much.
Dr. McKechnie.

STATEMENT OF FRANKLIN B. McKECHNIE, M.D. PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, WINTER PARK, FL

Dr. **McKechnie**. Mr. Chairman, members of the committee, my name is Franklin McKechnie. I am a practicing anesthesiologist from Winter Park, FL, and president of the American Society of Anesthesiologists, a group of some 21,000 physician anesthesiologists.

I am pleased to present ASA's comments on some of the physician reimbursement proposals under congressional review.

My remarks may be better understood if I briefly describe what we do in a broad sense. The anesthesiologist's responsibilities include, among other things: First, the preoperative evaluation of the patient's medical history, the preoperative evaluation of the physical condition, and prescription of an anesthesia plan;

Second, monitoring and maintenance of the patient's vital functions during the course of the operative procedure;

Third, the immediate diagnosis and treatment of potential life-threatening complications and other medical problems that might arise during and after completion of the operative procedure.

From this perspective, then, we offer the following comments:

With regard to the administration's proposed rulemaking on inherent reasonableness, ASA believes this rule would allow HHS unilaterally to set a national price and utilization level for a medical service when it determines that the regular reimbursement formula simply is not working. ASA believes that this is an important issue and best addressed legislatively.

We note that S. 2368, the Medicare Physician Payment Reform Act of 1986, seeks to address some of the issues raised by HCFA's inherent reasonableness proposal. We recommend that as the committee reviews this bill, it considers at least the following points:

First, Congress should specifically place limits on the capacity of HHS to define "reasonableness" on a national basis.

Second, statutory language should be included requiring a quality of care review as an integral part of any final rulemaking. This would ensure that anticipated impacts on the quality and availability of medical care is fully investigated.

With regard to the development of a relative value system, we would note that for over 20 years the American Society of Anesthesiologists has published a relative value guide, or an RVG, for determining reimbursement for anesthesia care. HCFA now mandates the use of an RVG by Medicare carriers, and the carriers use a variety of guides, including ASA's, in determining reimbursement levels for that care.

In any discussion of an anesthesia relative value system it is important to understand that the surgical and anesthesia complexity are not identical. Each medical service has its own unique responsibilities to the patient that result in varying degrees of complexity and of risk.

We believe that a relative value guide which considers both the complexity of the anesthesia service and the time required to perform this service is the most appropriate method. Inclusion of time in this formula, serves as a cost-saving factor where technological advancements reduce the time required to perform a particular surgical procedure.

In our judgment, payments should therefore be based on the intensity of care and commitment to the patient, and not on some average amount of care. We recommend the inclusion of these anesthesia concepts in any RVS based payment method.

We would object to suggestions to include anesthesiologist services, among others, into a hospital PPS system or a DRG physician payment scheme. As outlined in our written testimony, ASA believes that averaging payments for DRG purposes could create incentives for hospitals to reduce the availability of quality anesthesia care in order to save costs.

With regard to standby anesthesia, several Medicare carriers have adjusted reimbursement levels for so-called standby particularly in connection with cataract surgery, as Dr. Spivey has mentioned. And in some instances, with other surgical procedures as well.

The administration's fiscal year 1987 budget also proposes to limit standby anesthesia in order to produce annual Medicare savings of $70 million. ASA believes that these actions will reduce the quality of anesthesia care provided to Medicare patients.

Standby anesthesia is a badly misunderstood term. To some, it simply means the anesthesiologist's availability somewhere in the hospital. More commonly, standby anesthesia is used to refer to instances in which the anesthesiologist is physically present in the operating room, is monitoring and maintaining the patient's vital signs, and is ready to administer anesthetics or other necessary drugs and needed care to the patient.

This physician service is best described not as "standby anesthesia" but as "monitored anesthesia care," and involves full medical service to the patient comparable to cases where general or regional anesthesia is used.

It should be noted that monitored anesthesia care may indeed involve a greater demand and greater skill, in view of the fact that the sedated patient under local anesthesia is breathing on his own, and is therefore in an uncontrolled state. It is anything but a reduced service, and using inherent reasonableness as a way to address this issue is a serious mistake.

In our written testimony, ASA has described services that must be provided in order to pay full amount for this type of care. We are now discussing this issue with HCFA. I believe our discussions have been positive. And while we have not yet reached a conclusion, we hope to, and we will keep you so advised.

I thank you for your time and would be pleased to answer questions.

Senator Durenberger. Thank you very much.

Dr. Hanlon?

[The prepared statement of Dr. McKechnie follows:]

STATEMENT OF FRANKLIN B. McKECHNIE, M.D.

PRESIDENT OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

BEFORE THE

SUBCOMMITTEE ON HEALTH

SENATE COMMITTEE ON FINANCE

APRIL 25, 1986

Mr. Chairman and Members of the Committee. My name is Franklin B. McKechnie. I am a practicing anesthesiologist in Winter Park, Florida and the current President of the American Society of Anesthesiologists, a national medical society with a membership of 22,000 physicians or other scientists engaged or professionally involved in the medical practice of anesthesiology. I am pleased to present ASA's views on Medicare reimbursement of anesthesia services, and to offer our comments and suggestions regarding some of the proposals relating to physician reimbursement now being considered by the Congress and the Administration.

My remarks may be better understood if I briefly describe what an anesthesiologist does. Our most important function is to administer a number of drugs to render patients insensible to pain during surgical and obstetrical procedures. In most cases, these drugs suppress the patient's ability to maintain his own life. It is the anesthesiologist who is responsible for keeping the patient alive by assuring that essential physiologic systems properly function during the course of the anesthetic. This is done by:

-- Performing the pre-operative evaluation of the patient's medical history and physical condition, and prescribing the appropriate anesthesia plan based on the patient's informed consent;

- During the surgical or obstetrical procedure, monitoring such vital signs as blood pressure, pulse rate, color, temperature and heart sounds, and maintaining and supporting the patient's circulatory, respiratory and other vital functions; and
- Diagnosing and treating potential anesthesia-related life-threatening complications and other medical problems that may arise during the course of or after completion of the surgical or obstetrical procedure.

Our principal concern thus deals with the status of the respiratory, cardiovascular, hepatic, renal and central nervous systems. Our responsibilities to the patient arise in connection with, but independent of, the surgical or obstetrical procedure.

The drugs that are administered to achieve an anesthetized state are potentially lethal when used in inappropriate doses or improperly selected for a particular patient. Each patient must be evaluated by the anesthesiologist prior to the administration of the anesthetic. Then the anesthesiologist seeks to maintain the patient's physiologic function in as near a normal state as possible while rendering the patient insensible to pain during an operation. Finally, the anesthesiologist also has a responsibility for the patient's care during his or her recovery from anesthetic agents after the operation is finished.

RELATIVE VALUE GUIDE (RVG)

For over twenty years, ASA has published a relative value guide for the benefit of anesthesiologists, third-party payers and patients seeking to determine appropriate levels of payment for anesthesia care. The Health Care Financing Administration now mandates the use of an RVG by Medicare carriers; the carriers themselves use a variety of guides, including but not limited to those developed by ASA, in determining appropriate reimbursement levels for anesthesiologist services.

ASA's newest guide is based directly on the terminology contained in the anesthesia section of AMA CPT-4. HCFA currently has under study the issue whether this terminology is appropriate for use in connection with reimbursement of anesthesiology services under the Medicare program.

In any discussion of an anesthesia relative value system, it is important to understand that surgical complexity and anesthesia complexity are not identical. Each medical service has its own unique responsibilities to the patient that result in varying degrees of complexities and risks. Since our concern is primarily with the respiratory and cardiovascular systems, it stands to reason that surgery on these systems complicates the anesthetic procedure. This complication can be further compounded by the patient's physician condition, age, whether the patient smokes, positioning on the operating table, and a variety of other factors. These considerations form the basis for determining the respective values for each procedure set forth in ASA's relative value guide. We believe that use of an RVG continues to be the most accurate means for assessing, establishing and controlling reimbursement for anesthesia services. It is appropriate to note, however, that no individual anesthesiologist or insurer is under any compulsion to use the ASA guide and as noted, many different RVGs are in use for anesthesia services by Medicare carriers.

The current guide published by the ASA contains a listing of approximately 400 anesthesia procedures, among them (for example) the following: anesthesia for procedures on the upper abdomen (e.g., removal of a gallbladder); anesthesia for amputation of the lower leg; and anesthesia for removal of a lung or portion thereof. To create an RVG, one assigns to each procedure a number which, when compared to the number assigned another procedure, describes the relative complexity of the two procedures. In the examples I just cited, anesthesia for removal of a gallbladder has been assigned, in the current ASA guide, a value of "7", for an amputation of the lower leg "3", while surgery on the lung is valued at "15". In comparing these numbers one can see that anesthesia for lung surgery is regarded as almost twice as difficult as anesthesia for a lower leg amputation. This illustrates the point that the most complex procedures involve the respiratory and circulatory systems.

Another extremely important aspect of the relative value guide as used by anesthesiologists is the factor of time. Merely describing the relative complexity of various procedures does not take into account the wide range of time that surgeons may require to accomplish their tasks. As a consequence, all anesthesia relative value guides also include unit values for time -- usually one unit for each 15 minutes. Again, using one of the examples previously mentioned, the unit values assigned for anesthesia for removal of a gallbladder requiring 2.0 hours would be 15 (7 for the procedure and 8 for the time units).

ASA believes that an RVG relating both to procedure and to time is the most appropriate method of assessing the services performed by an anesthesiologist, since it considers both the complexity of the anesthesia service and the time required to perform these services under difficult medical and institutional settings. Applying a simple average time to each procedure would ignore these considerations and seriously distort payments; in our judgment, payment should be based on the intensity of care and commitment to the individual patient in question, and not upon simply some "average" amount of care.

The concept of reimbursement for anesthesia time serves as an inherent cost-saving mechanism that operates automatically when technological advances produce decreases in time required to perform a particular surgical procedure. These decreases result when surgical experience and skills combine with technological improvements to result in shorter surgical and anesthetic time.

This has been well demonstrated in several highly utilized and expensive surgical procedures; namely, cataract surgery, cardiac surgery such as cardiac valve replacement and coronary artery bypass procedures, and total hip replacements. Cataract surgery now usually requires only one to one and a half hours of time, in contrast to about three hours a decade ago. Cardiac surgical procedures which required six or more hours of anesthesia time initially, now need only three to four hours, while total hip replacement has decreased from five to six hours, to three to four hours. Since anesthesia time is independently considered in anesthesia reimbursement utilizing the relative value guide, savings in cost for the delivery of anesthesia care in connection with these procedures has already taken place, automatically.

Once an RVG has been constructed, the creation of an RVG-based fee schedule is simple. One need only establish what will be charged or paid per unit. This "conversion factor" is then multiplied by the RVG-generated number for the procedure in question, and the result is the amount of fee to be charged or reimbursed. We favor the RVG method because we feel it is fair for the patient, the physician and third party carriers. In addition, it provides a quick and objective measure of the appropriateness of a particular fee.

DRG-BASED PAYMENTS FOR PHYSICIANS

There have been suggestions raised that payment for services of anesthesiologists could be rolled into the hospital prospective payment system, with payment for the anesthesiologist's services being part of the DRG. We seriously question the necessity for such a change. TEFRA clarified the anesthesiology services that are properly paid under Part A and those that should be paid under Part B. We see no need to alter that arrangement.

Proponents claim that DRG-type payment for inpatient physician services would create incentives for greater efficiency, by holding out the opportunity to increase profits through more economical use of physician services or through possible use of lower-cost providers to provide care heretofore provided by physicians.

Numerous generic concerns have been raised concerning the DRG physician payment approach, including problems involved in determining whom to pay, how to divide DRG payments among the component specialists, and whether appropriate "average payments" for DRG purposes could in fact be created for all physician services involved in a particular procedure (particularly surgical).

A major issue would be the capacity to develop DRGs appropriate to the differing complexity of care being rendered by each physician specialist. As noted about, what may be a relatively simple surgical procedure, may be extremely complex from the perspective of anesthesia care, and vice versa. Using the same DRG to cover both services would be inherently unfair to one discipline or the other, and ultimately, to the patient or third-party payer.

The services that anesthesiologists provide are direct medical services to the individual patient. As noted earlier, the RVG determines a level of payment that takes into account the complexities and potential life-threatening complications of each individual case. The DRG system insofar as it relates to anesthesia services, would not be able to take these complexities into account.

The necessary averaging of patients under such a system would not only yield inappropriate payments for some procedures, but could create incentives for reduction in availability of quality anesthesia care. If a DRG system were applied to anesthesia care, a number of medically disturbing incentives become apparent:

-- Incentive not to provide certain physician services or "packages" of services, where payment is deemed inadequate, thereby limiting scope of care available in a hospital or, perhaps, in a community.

-- Incentive to cut back or eliminate preanesthetic patient visits or post-anesthetic evaluation and care, in order to be able to "process" more patients.

- Incentive to avoid the "slow" surgeons, even though those surgeons may possess high technical skills and anesthesia-related patient safety considerations may be best served in proceeding more slowly.
- Incentive to dilute the ratio of (or eliminate) anesthesiologist medical direction, to optimize use of "low-cost" providers, notwithstanding the limited medical training and skills of such non-physician providers.

We believe that these negative incentives would place the patient at risk and create the potential for a higher incidence of adverse anesthesia-related inquiries. It should be noted that the current trend in anesthesia care is to require more skilled personnel -- not less; more pre-anesthetic evaluation, intraoperative patient monitoring, and postanesthetic care -- not less; and more direct involvement of anesthesiologists in supervision of nurses -- not less. Stated very simply, profit-oriented "efficiency" and quality-oriented anesthesia care are not always synonymous.

It is principally for these reasons that ASA finds the DRG physician payment approach inappropriate, and advocates the use of an anesthesia relative value guide methodology as the reimbursement system consistent with the need for a high level of patient care.

"STANDBY" ANESTHESIA

The Administration's fiscal year 1987 budget contains a proposal to issue regulations limiting payments to physicians who provide "standby" anesthesia services. We understand that the Administration expects that implementation of this proposal would result in savings of some $70 million annually.

In our view, the Administration's proposal to limit payment for "standby" anesthesia is based on the mistaken conclusion that reduced services to Medicare patients are somehow involved. This we believe is principally due to the confusion surrounding the term "standby" anesthesia.

We think it is important to make sure that the term "standby" anesthesia is understood. The term has been used by some to refer to physician availability somewhere in the hospital: both ASA and HCFA agree this is not a physician service reimbursable under Medicare Part B.

The term "standby" has also been used to refer to instances in which an anesthesiologist has been called upon by a surgeon or an obstetrician to provide specific anesthesia services to a particular patient undergoing a planned surgical or obstetrical procedure, in connection with which the surgeon or obstetrician administers local anesthesia or, in some cases, no anesthesia at all. In such a case, the anesthesiologist is providing specific services to the patient and is in control of his or her non-surgical or non-obstetrical medical care, including the responsibility of monitoring of his or her vital signs, and is available to administer anesthetics or provide other medical care as appropriate.

The preamble to the Medicare TEFRA regulations specifically acknowledges that "standby anesthesia" is, under these latter circumstances, a physician service to the individual patient and thus reimbursable under Medicare Part B.

HCFA has advised its carriers to reimburse physicians for this service "the same as for any other anesthesia procedure," provided that the physician is physically present in the operating suite monitoring the patient's condition, making medical judgments regarding the patient's anesthesia needs, and ready to furnish anesthesia services as necessary.

Despite this statement, some Medicare carriers have somehow concluded that reduced services by the anesthesiologist are somehow involved. This misunderstanding has resulted in reduced third-party reimbursement in certain parts of the country. We believe that reduced reimbursement creates a potential for reduced availability of services to Medicare patients, as well as for less than adequate care for many such patients at risk because of advanced age or complicating medical problems.

ASA believes the participation of an anesthesiologist in the case of an individual patient undergoing cataract surgery, for example, is often critical to the provision of sound medical care and should be subject to reimbursement at the same level as if a general or regional anesthetic had been administered. ASA believes that proper resolution of the issues raised by the budget proposals and the carriers' actions requires not "across the board" reductions in physician reimbursement, but a more precise definition of the circumstances under which such care is medically necessary and therefore fully reimbursable.

ASA first recommends that a more accurate term should be used to describe those instances in which the anesthesiologist, consistent with HCFA's present reimbursement regulations, is physically present and is providing direct anesthesia care to the patient under the circumstances described a moment ago. We believe that a more appropriate term would be "Monitored Anesthesia Care," which would properly include the following requirements:

1. The service shall be requested by the attending physician and be made known to the patient, in accordance with accepted procedures of the institution.
2. The service shall include:
    a. Performance of a preanesthetic examination and evaluation.
    b. Prescription of the anesthesia care required.
    c. Personal participation in, or medical direction of, the entire plan of care.
    d. Continuous physical presence of the anesthesiologist or, in the case of medical direction, of the resident or nurse anesthetist being medically directed.
    e. Proximate presence or, in the case of medical direction, availability of the anesthesiologist for diagnosis or treatment of emergencies.
3. All institutional regulations pertaining to anesthesia services shall be observed, and all the usual services performed by the anesthesiologist shall be furnished, including but not limited to: a) Usual noninvasive cardiocirculatory and respiratory monitoring; b) Oxygen administration, when indicated; and

c) Intravenous administration of sedatives, tranquilizers, antiemetics, narcotics, other analgesics, beta-blockers, vasopressors, bronchodilators, antihypertensives, or other pharmacologic therapy as may be required in the judgment of the anesthesiologist.

If these requirements are not met, then the anesthesiologist should not be entitled to reimbursement under Part B for Monitored Anesthesia Care.

We are currently engaged in discussions with HCFA concerning this issue. Dr. Jess Weiss, M.D., who is the Chairman of ASA's Committee on Economics, has led these discussions. Our objective is to find a means by which reimbursement remains appropriate to the level of care rendered to each patient, taking into account the judgment and medical skill involved, the risks presented by the procedure and the patient's condition, and the time expended by the anesthesiologist in performing the procedure. It would be unfortunate if this issue were dealt with simply in budgetary terms. Indeed, we suggest that such a course would be ill-advised, and that careful study of this matter is required if we are to avoid doing a serious disservice to Medicare patients.

"INHERENT REASONABLENESS"

The Administration has proposed a rulemaking relating to the "inherent reasonableness" of Part B charges. Basically this rule seeks to set a system for setting a national price when the government determines that the regular Medicare reimbursement formula is not working properly. This proposal is aimed at reducing what Medicare considers to be "excessive" charges.

A number of groups have raised serious questions about the merits of this proposal and have also challenged the apparent lack of statutory authority for the rulemaking. This is an extremely important matter for physicians and their patients.

ASA believes that this is an issue on which Congress should take the lead. Because of the substantial patient care implications involved in the Administration's proposal, we believe that statutory language is required, limiting the circumstances under which HCFA can alter well-established reimbursement patterns that may have been in place for many years and have been created consistent with existing reimbursement rules. In essence, we think that a change in methodology of this magnitude should come about, if at all, only through a change in the Medicare law and not through a regulatory interpretation.

We have noted that the proposed "Medicare Physician Payment Reform Act of 1986" seeks to define some of the factors that HCFA may consider in determining inherent reasonableness. We recommend that when Congress reviews this proposal, it also should take account of the following points relevant to the inherent reasonableness concept: First, Congress should specifically place limits on the capacity of HCFA as an administrative agency to define "reasonableness" essentially on a national basis. Not only is this required as a matter of administrative law, but we believe it essential if HCFA is to be given authority unilaterally to determine reasonableness.

Second, a mechanism should be included by which patients and providers can also raise generic issues concerning the reasonableness of reimbursement levels. Opportunities under the Medicare laws to obtain objective resolution of such issues are limited indeed, and if HCFA is to have the power to initiate such review, so also should patients and providers.

Third, we recommend that statutory language on "inherent reasonableness" requires a quality-of-care review with respect to any proposed or final rulemaking by the Secretary on changes to payments for a physician service. This quality-of-care requirement would address the potential or actual impacts on the delivery of quality medical care to the patient, including changes in the risk to the patient, as well as access to and delivery of medically needed services.

In closing, Mr. Chairman, we note that issues have been raised about the current Medicare system for paying for physician's services. ASA believes that the Congress should carefully consider how a relative value system can be properly designed; and we believe our experience would be helpful in such an effort.

I would be pleased to answer any questions.

STATEMENT OF C. ROLLINS HANLON, M.D., F.A.C.S., DIRECTOR, AMERICAN COLLEGE OF SURGEONS, CHICAGO, IL

Dr. HANLON. Mr. Chairman, Senator Mitchell, I am Rollins Hanlon, director of the American College of Surgeons and a fellow of the college, on whose behalf I am here today. The college is appreciative of this opportunity, and in the interests of time, Mr. Chairman, I will simply highlight significant parts of our testimony.

The college represents 55,000 surgeons in the United States and elsewhere in the world. It has close liaison with the 11 surgical specialties, and a majority of these specialties have endorsed in principle our testimony here today.

Together with these specialties, our physician reimbursement committee is reviewing provisions of the physician payment bill recently introduced under your aegis and that of other members of the Senate Committee on Finance. We will provide a joint analysis of that bill as soon as possible.

We believe there are faults in the design of the present system for Medicare payment of physician services and that improvements should be made. These improvements should take into account several factors: access to care, cost to beneficiaries, degree of participation by physicians, and it should provide incentives for providing a high quality of care.

In reviewing these topics—access to care, quality of care, beneficiary cost, and participation by physicians—the college has been examining methods for defining physician services, developing appropriate payment units, and evaluating the physicians' personal services. We have concentrated our efforts on four areas: definition of payment units, fee variations, assistance at surgical operations, and physician participation.

With regard to the definition of payment units, the college emphasizes that an effective payment system requires exact definition of the units to be reimbursed. We believe surgical experts should be involved in the development of technical definitions for high quality surgical services. In addition, the college is discussing with representatives of the surgical specialty societies a number of policy proposals that could move the Medicare Program toward improvements in present coding procedures and definition of services.

I may say, as an important aside, Mr. Chairman, that for many years the college has supported the global fee concept in which a single fee takes care of the cognitive services provided by surgeons in preoperative, operative, and postoperative periods.

With regard to fee variations, the college recognizes the problems associated with these variations. One option that Congress might consider for addressing this issue is the development of a process to determine which services should be reimbursed at a different level when they are provided by a specialist rather than by a generalist, a subject which has been mentioned earlier today.

The college also is discussing with the surgical specialty societies an arrangement under which Medicare carriers serving more than one medical service area in a State and using a single definition should work toward a comparable value system to be applied throughout the State.

The college believes that services by relatively untrained individuals at any level are not equivalent to those provided by skilled, well-educated specialists. The idea that anyone who attempts a procedure can do it as well as a well-educated specialist is, to us, simply untenable. Education is important both to achieve the necessary fund of knowledge and to develop a professional attitude of responsibility in adapting that knowledge to important decisions affecting life itself.

With regard to assistants at surgery, together with the surgical specialties we are developing policy as to the circumstances of payment for an assistant at surgery, including the nature of the assistant to be used.

Finally, on physician participation, we are looking at ways to increase that participation. One possibility is to test the effect on physician participation if Medicare pays the entire allowable fee for a service directly to the physician taking assignment. Another possibility is to pay physicians at the beginning of each month an amount equivalent to their projected monthly billings.

In concluding, the American College of Surgeons is vigorously addressing physician payment reform. And while our efforts are incomplete, we expect substantial progress by June 1986, and we will share our conclusions and recommendations as we reach them.

In this process we are guided by four principles we outlined for this committee a few months ago, when we discussed our views, and these principles are:

No. 1, to avoid changes in payment methodology that would have undesirable consequences for beneficiaries from the standpoint of loss of access to care, compromises in quality of care and burdensome increases in beneficiary costs;

No. 2, support the best practice of medical care as is now provided, and encourage continued improvements in clinical diagnosis and treatment;

No. 3, to make future cost for services more predictable and acceptable; and

No. 4, to provide a system of administration that will assure effectiveness and fairness.

We believe these goals are appropriate for all parties seeking improved physician payment policies under Medicare. We appreciate the opportunity to present our views and those that have been accepted in principle by the following surgical specialty societies, as indicated in our testimony.

We will be pleased to answer any questions, Mr. Chairman.

Senator DURENBERGER. Thank you, Dr. Hanlon.

[The prepared statement of Dr. Hanlon follows:]

Statement
# of the
American College of Surgeons

to the

Subcommittee on Health
Committee on Finance
United States Senate

Presented by

C. Rollins Hanlon, M.D., F.A.C.S.

RE: Proposals to Modify Medicare's Physician Payment System

April 25, 1986

American College of Surgeons
55 East Erie Street
Chicago, Illinois 60611
(312) 664-4050

Mr. Chairman and Members of the Subcommittee:

I am Doctor Rollins Hanlon, Director of the American College of Surgeons, and a Fellow of the College, on whose behalf I appear before you this morning. The College appreciates your invitation to share with you the views of its members about physicians' payments under Medicare.

The American College of Surgeons, Mr. Chairman, is a 73-year-old voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high quality care for the surgical patient. The College provides extensive educational programs for its Fellows and for other surgeons in the United States and elsewhere in the world. It also cooperates in the education of nurses and allied health care practitioners. In addition, the College establishes standards of practice, disseminates medical knowledge and provides information to the general public.

In 1918, the College established the nation's first voluntary hospital standardization program, designed to improve the level of patient care in hospitals. It supported this program with its own funds for 35 years. Out of this effort came the Joint Commission on Accreditation of Hospitals (JCAH), the nation's principal hospital survey and accreditation body, of which the College is a member. To achieve the goal of excellence in the provision of high quality surgical services for patients, the College also maintains strong bonds with physicians in the various surgical specialties through representation on its Board of Governors, as well as through advisory councils from 11 surgical specialties. There are 85 chapters of the College in the United States and other countries throughout the world.

Your invitation to us is quite timely. Physician payment reform is an increasingly important issue, and the College has undertaken a major effort to develop policies and proposals to influence the agenda for reform. While our efforts have not been completed, we are glad to present a status report of our activities consistent with general College policy in the various areas we are exploring.

Mr. Chairman, the College shortly will convene its physician reimbursement committee to conduct a careful review of the provisions of the physician payment bill that was introduced a few days ago by you and several other Senators on the Committee on Finance. We will study the legislation carefully and provide you with an analysis by the College with input from the surgical specialty societies as soon as possible.

Recent increased interest in physician payment modifications derives much of its impetus from the urgent quest for budget savings. We believe that the present system used by Medicare for the payment of physicians' services is faulty in some respects in its design and that improvements in payment policy should be considered. These improvements should address some of the defects that are part of the current payment methodology, take into account patient access to care, consider beneficiary cost, enhance physician participation, and provide incentives for the provision of high quality in patient care services.

With these goals in mind, the payment policy issues that the College has been examining include: methods for defining physicians' services, appropriate payment units for reimbursement purposes, and valuation of the professional services of the physician. As the College has reviewed these matters, it has concentrated on four areas:

- Definition of payment units
- Fee variations
- Assistance-at-surgery

- Physician participation

Definition of payment units

The College emphasizes that an effective payment system requires definition of the units to be reimbursed. The present Medicare system of paying physicians is based upon the Physicians' Current Procedural Terminology, embodied in Medicare's Health Care Procedure Code System (HCPCS). Unfortunately, Mr. Chairman, such coding systems do not always define fully and precisely the content of services indicated under a given identifier code. For example, the surgical codes do not specify the length of the postoperative period for a particular operation. Codes that describe office visits or visits to hospital inpatients lack precision. There is an attempt to convey the time or degree of complexity of care provided by use of words such as "intermediate," "extended," or "comprehensive." But there are no programwide, accepted standards used by Medicare carriers to establish a payment basis for these services. The full definition of a service varies widely among carriers and physicians. As a result, different services might be reported under a single code.

The current coding system and service definitions also have been criticized on other grounds:

1. The procedural terminology contains a large number of codes, which has led to "unbundling" of services.
2. Imprecise definition of services may lead to a selection bias toward the higher valued codes, or "upcoding." This is especially likely if the complexity or intensity of a service is poorly defined.
3. There may be an incentive to charge separately for services that could be included in a package for which

a single, comprehensive fee would be charged. For example, the American College of Surgeons has supported for years this type of "global fee concept" that packages in a single fee the cognitive aspects of surgical care in the preoperative, operative and postoperative period.

4. There may be a significant lag between the introduction of new services and incorporation of appropriate codes and service definitions into the payment system.
5. Finally, vague definitions make it difficult to compare charges for similar services between areas, carriers, or individual physicians.

The College currently is discussing with representatives of the surgical specialty societies a number of policies and proposals that could move the Medicare program toward improvements in present coding procedure and service definitions. The College believes that modification of current codes and definitions may take considerable time and effort and that such a modification process should continue indefinitely as existing services change and new services are created. We believe surgical experts must be involved in the development of technical definitions for high-quality surgical services. It is essential, therefore, that surgery be represented on the Physician Payment Review Commission, mandated by P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act.

Fee Variation

A frequent criticism of Medicare's payment process is irrational variation in fees. Fee variations occur according to geographic areas, practice settings, or whether a service is provided by generalists or specialists. It is doubtful that a self-designated "specialist" actually has the education and special training required for providing the highest quality in a specialized service. Presently, the definition of a specialist varies among carriers.

An important source of misunderstanding about variations in physicians' fees is the Medicare Economic Index (MEI) used to make annual adjustments in the prevailing charge level for specific services in different locales. We believe that, for at least 14 years, this index has failed to take account of the varying economic factors that affect different specialties in different geographic areas. For example, the factor of the cost of professional liability insurance varies greatly among specialties and localities. By using the MEI, Medicare has established a fee schedule for physicians' services that no longer reflects either the economic or professional factors that influence the charges for these services. Furthermore, charges for new services are not recognized adequately by the program. Provision should be made to maintain a reasonable price relationship between new and old services.

The College recognizes the problems associated with fee variations and has been discussing possible proposals related to our policy on this issue. One option the Congress might consider is the development of a process to determine which services should be reimbursed at a different level when they are provided by a specialist rather than by a generalist. A single, programwide definition of a specialist for payment purposes also may be appropriate.

The College believes that services provided by relatively untrained individuals at any level are not equivalent to those provided by skilled, well-educated specialists. The idea that anyone who performs a procedure can do it as well as a specialist is clearly an untenable position. Education is important, both to achieve the necessary fund of knowledge and to develop a professional attitude of responsibility in adapting that knowledge to important decisions affecting life itself.

The College also is discussing with the surgical specialties an arrangement under which Medicare carriers serving more than one medical service area in a state and using a single definition of services in all its areas should work toward a comparable value system for application throughout the state. We might allow for price variations among geographic areas by using standard unit values that reflect price and cost variations in factors such as professional liability insurance premiums. Such arrangements would represent an important move toward reducing unreasonable variations in prevailing fees among geographic areas. If such a step were to be taken, we should be careful to avoid disruptive effects from sudden changes in prevailing fees. Patients could be adversely affected if participation by some physicians were decreased by sharp changes in prices.

The College also is studying alternative approaches to applying a single index to adjust all prevailing fees from year to year. An improvement in this area might constitute an important step toward more rational pricing to deal with the problems caused by use of the present Medicare Economic Index.

Assistance-at-Surgery

Payment for assistance at surgery is already undergoing change as a result of certain provisions in P.L. 99-272. Such change must be made with care because assistance-at-surgery is often an essential ingredient in providing the patient with optimal benefits from surgical techniques. Together with the surgical specialties, we are developing policy as to the circumstances of payment for an assistant-at-surgery, including the nature of the assistant to be used.

Physician Participation

In considering actions that could affect the level of payment for physicians' services, it is important to recognize the effect of such actions on beneficiaries. We need to avoid the disadvantage of increased cost to beneficiaries or decreased access to care. Therefore, when considering payment changes we need to review possible effects on physician participation and the acceptance of assignment. It is clearly advantageous to patients, physicians, and the government to set allowable fees at a level sufficient to ensure the participation of most physicians in the community.

We are looking at other ways to increase physician participation in the Medicare program. One possibility is to test the effect on physician participation if Medicare pays the entire allowable fee for a service directly to the physician taking assignment. Under this plan, Medicare would collect from beneficiaries their copayments or Medi-gap coverage. Another possibility is to pay physicians at the beginning of each month an amount equivalent to their projected monthly billings. This suggestion is patterned after the periodic interim payments to hospitals.

Concluding Remarks

The American College of Surgeons is vigorously addressing physician payment reform. While our efforts are not complete, we expect substantial progress by June of 1986. We will share our conclusions and recommendations as we reach them. In this process, we are being guided by four principles that we outlined for this Committee a few months ago when we discussed our views about possible reform of Medicare payments to physicians. These principles are:

1. to avoid changes in payment methodology that would have undesirable consequences for beneficiaries from the standpoint of 1) loss of access to care, 2) compromises in quality of care, or 3) burdensome increases in beneficiary costs;
2. to support the best practice of medical care as now provided and encourage continued improvements in clinical diagnosis and treatment;
3. to make future costs or services more predictable and acceptable; and,
4. to provide for a system of administration that will assure effectiveness and fairness.

We believe such goals are appropriate for all parties seeking to improve the physician payment policies under Medicare.

The American College of Surgeons appreciates the opportunity to present our views on this issue, which is of considerable interest to the surgical profession. Our views have been accepted in principle by the following surgical specialty societies:

American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology - Head and Neck Surgery, Inc.
American Association of Neurological Surgeons
American Association for Thoracic Surgery
American Society of Colon and Rectal Surgeons
American Society of Plastic and Reconstructive Surgeons
The Society of Thoracic Surgeons

Thank you.

April:20

Senator **Durenberger**. I have a variety of questions of each of you, because of the specific nature of your testimony and your contributions, which I will submit in writing.

Dr. Sammons, you indicated somewhere in your statement that you think there is ample justification for the 7,500 physician service codes and the 2,500 nonphysician codes in what we call the HCPCS, H-C-P-C-S. Five hundred of those codes, I am told, account for more than 90 percent of Medicare's physician expenditures. I am wondering how you justify this. You think we ought to justify this high volume of distinction.

Dr. **Sammons**. Well I think you have to begin with the basic reason for having the codes in the first place. The codes were never designed to be a vehicle for payment; the codes were designed to accurately reflect what the physician does in treating the patient. And with the multiplicity of regimens that are now available and the high technology and the multiple procedures that can be done today, it takes that many codes to accurately describe and reflect what the true nature of the service is.

Now, the fact that the codes are being used in a measure that couples with reimbursement or payment is fine, splendid, if that is the best vehicle, and we believe it is the best vehicle, to reimburse at this moment, until the RVS is finished. And then we believe that the RVS, once it is done, will be the best method of computing this; but the justification for the 7,500 codes, Senator, is simply that that series is an accurate description of what is actually done.

Senator **Durenberger**. Dr. Spivey, you indicated in your testimony that there is strong evidence of a highly competitive market in cataract surgery. I wonder if you would describe that evidence for us. You have indicated that there has been a substantial increase in the supply and distribution of ophthalmologists; has there been a concommitant decrease in fees which tells us there is a competitive market for those services? And if so, where is the pressure to decrease fees coming from?

Dr. **Spivey**. Well, there has been a reduction in fees in certain surgical procedures that have been considered more cosmetic. But in terms of cataract surgery, which I believe is your question, there is no indication that I am aware of where there has been a fee reduction.

I do believe that the majority of ophthalmologists have held their surgical fees within what would be, in my description, "a reasonable increase."

I suspect, and I believe, that there are ophthalmologists who have charged more than what I think would be reasonable. And it was to that point that I was addressing my comments earlier.

I think if a reduction in a fee for cataract would be established, it should be at the top and not penalize those who have held their fees over the years at a low level. I would be happy to either in writing or in further comment expand on that, if that were desired.

Senator **Durenberger**. Are there overpriced ophthalmologists, or overpriced procedures, right now? Or both?

Dr. **Spivey**. Well, I don't know how you unbundle those two. In my judgment there are individuals who charge what would in the recent parlance of the DRG's be considered the level of an outlier.

And let us look at the outliers and not spend an awful lot of time with everyone else.

Senator **Durenberger**. George Mitchell?

Senator **Mitchell**. I thank you, Mr. Chairman.

I believe you gentlemen were present during the earlier panel when I asked a series of questions regarding the problem of the maldistribution of physicians and what ways we could create incentives for physicians to locate in underserved areas. I also commented on the differences in charges for similar or identical services.

I wonder, if you recall those questions, if you might each comment, and give any suggestions you might have in that area. Comment briefly, because I have another follow-up question.

Dr. **Sammons**. Senator, I will be happy to start the answer to that.

First of all, I don't think that price and price alone is the attraction for a physician to practice in a rural or an urban area. I started my practice in a rural area, and I assure you it was not on price.

I think if we really want to attract doctors to rural areas that we have to look at the circumstances of their practice, whether they are isolated, professionally isolated, whether they have other physicians whom they can consult with, the whole gamut of human reactions that occur.

Having said that, let me remind you that some years ago Senator Talmadge attempted to address that same problem in the proposed Talmadge bill back 10 or so years ago. On the question of equal pay for equal service, which is a question that you have asked a couple of times today, Senator Talmadge attempted to address that question as well.

The difficulty with that is that you have to then make the assumption that it is always cheaper to maintain a practice in a rural area than it is in an urban area, and that is not necessarily true. Admittedly, per-square-foot rental is higher in the urban area, and a lot of other factors including labor cost; but, on the other hand, physicians who are truly in really rural areas that have to provide their own laboratory equipment, their own x-ray equipment, have to maintain an office, don't necessarily do it at a great deal less. So, there is a great justification for the concern that you have expressed about equal pay for equal service. I think that needs to be carefully explored. We will be happy to explore that with the committee or its staff.

I would tell you that in the recent recession we did see a migration of physicians, a substantial migration of physicians, into rural and small town America.

I suppose you could do it, but it would be very difficult today in this country, in a town of 15,000—which is not necessarily a rural community, but a town of 15,000—to not find all of the major specialties represented at least once. And that in great part is a result of the recent recession; that was not true uniformly across the country until the recession.

Senator **Durenberger**. George, I don't think we have time for a similarly brief reaction from the other three witnesses. [Laughter.]

Dr. **Sammons**. I think that is the answer to your question, though, in spite of the chairman.

Senator MITCHELL. Right.

Dr. SPIVEY. I would like to just make one comment. We watched where ophthalmologists practice over the past decade, and they have moved farther and farther from the urban areas. I think that many of the studies that are quoted are old studies, and I think, with the physician oversupply in every specialty, this issue of maldistribution by geography is something that is going to be addressed, and you don't have to spend an awful lot of time about it. It is going to be addressed by the physicians themselves.

Dr. MCKECHNIE. May I respond to that as well? As far as anesthesia is concerned, we know that our residents now are moving out into the rural areas.

We have an added push behind it, in that, to a degree, we are limited by the number of operating rooms available. Now that hospitals have filled up in the cities beginning with the great rush into anethesia practice that came after the War, our current residents are not finding places to work, and they are moving out into more rural settings.

In addition, they are probably smarter than we were; they are looking for a better lifestyle with more home life and so forth.

I believe it is a question that, in part, be addressed with the development of more anethesiology residents moving out into these settings.

This, of course, requires that good surgeons either precede us or go with us.

Dr. HANLON. I can be very brief with regard to rural/urban distribution. I spoke to Senator Talmadge's hearings some years ago, and that is on the record. With regard to identical services given by generalists and specialists, I think that is an extremely important issue that Senator Mitchell has raised, and our feelings on that are clearly stated. I adverted to them in my comment; which is to say that I believe it is untenable to say that someone who is not highly skilled can perform an identical service to someone who is merely attempting the procedure, whether he should do it or not.

Senator MITCHELL. I have to say, Doctor, I don't think that is the issue. The question is, if both persons possess the level of skill necessary to perform the particular service, and one has more training and skills which are not necessary to perform the particular service, should that person be paid more for only that service merely by virtue of the higher level of training and skill?

If I may state an extreme example to make the point, if I want to get my car washed and I had a choice between a person who had no education but could wash a car, and a lawyer, and a surgeon, all three of whom could wash the car, I don't feel I should have to pay more for the surgeon or the lawyer to wash my car just because they are persons of greater educational skills, because the education and skills are not necessary to perform the particular service.

The question really is, when you have a general practitioner who is fully equipped to perform a particular service but does not possess the same level of training or skill as say a specialist who also can perform the service, should the specialist be paid more for that particular service? That really is the question, not in the area of a person who possesses skills against one who doesn't possess skills. I think that is what makes it more narrow. I believe that justifies the position that we ought to pay the same amount for the service if the person involved has skills requisite to perform the service.

Dr. **HANLON**. To respond to two poles of your question: One is, if you had an open-heart procedure that you would have done by the best lawyer in the country, I think that you would be hesitant about that—setting aside the car-washing analogy.

With regard to the question of whether—the emphasis on skill, I think, tends to bias the question in a way that it sounds as though this is a procedural, technical thing. And the most important thing about doing an operation is, first of all, that you decide on the right one; second, that during the procedure you are fully conversant with all possibilities, can modify the treatment in its course by the most delicate technical and cognitive conjunction; and finally, in the postoperative period, that you not turn it over to someone who is palpably incompetent. And that may not be obvious, but it appears to be very conducive to that sort of technique, in which a surgeon does an excellent procedure, turns it over to someone who is not skilled, moreover was not aware of what went on during the procedure.

I think, and the college has maintained this for decades, that this is inappropriate, and it is one of the concomitants of itinerant surgery which we impugn.

Senator **MITCHELL**. My time is over. I just want to say that your statement persists in attributing to me a contention that I did not make. I do not suggest that a person without skills should be called upon to perform a service which requires certain skills. The question is a different one. It is, when two persons possess skills necessary to perform a particular service, and one has a higher level of training and skills that are not necessary for that service. You keep reversing it the other way. But I won't pursue it any further.

I thank you very much, Doctors, for your testimony.

Senator **DURENBERGER**. Gentlemen, thank you very much for your testimony; I appreciate it a lot.

Dr. **HANLON**. Thank you very much, Mr. Chairman, and members of the committee.

Senator **DURENBERGER**. All right. We now have a panel consisting of Dr. Harry L. Metcalf, chairman of the board of directors of the American Academy of Family Physicians; Dr. T. Reginald Harris, president of the American Society of Internal Medicine; and Dr. John McGrath, member of the board of trustees of the American Psychiatric Association.

Gentlemen, we thank you for being here. Your full statements will be made part of the record, and you may proceed to summarize those statements in 5 minutes, beginning with Dr. Metcalf.

[Senator Durenberger's further questions of the previous panel follow:]

[No response at press time.]

STATEMENT BY HARRY L. METCALF, M.D., CHAIRMAN, BOARD OF DIRECTORS, AMERICAN ACADEMY OF FAMILY PHYSICIANS, WILLIAMSVILLE, NY

Dr. METCALF. I am Harry L. Metcalf. I am a practicing family physician from Williamsville, NY, and I represent the American Academy of Family Physicians.

We appreciate the opportunity of being able to appear before you.

I would like to summarize our statement by making some major points which we feel are very important in addressing this important issue before you.

The Medicare Program has been an important mechanism in providing access by the elderly to health care. The family physicians of America support the reexamination of the Medicare physician reimbursement system, which may lead to a greater access to services and a greater and efficiency in the provision of these services.

We are deeply concerned by the patterns developed in Medicare that have diminished the ability of the elderly to receive preventive and primary care services. A number of our concerns have been detailed in my written statement.

Among some of our major concerns are that family physicians are locked into a low profile of reimbursement due to specialty discrimination, geographic discrimination, and the fee freeze. There is an historic imbalance in the reimbursement for cognitive versus procedural services.

There are uncovered services critical to the elderly, such as prevention, that are often not covered.

We would like to commend Senators Durenberger, Dole, and Bentsen for introducing such an improvement in the procedures for Medicare reimbursement payment. We will submit a written statement, after these proceedings. In particular, we applaud the fact that this legislation recognizes that the inherent reasonableness of charges needs to be addressed in terms of whether they are grossly deficient as well as grossly excessive.

We are also pleased that this bill provides that the RVS, to be developed pursuant to the Budget Reconciliation Act, reflects cost and resource requirements of providing services.

As detailed in our written statement, the American Academy of Family Physicians does not support the proposed adjustment in the Medicare economic index, and is concerned that the index does not accurately reflect inflation and increasing costs of providing medical care services.

The committee has before it many thoughtful proposals worthy of its deliberation. The academy and the family physicians of America look forward to the opportunity to improve the operation of this Medicare system which has meant so much to our elderly, and with the recommended improvements will continue to mean more.

Thank you.

Senator DURENBERGER. Thank you very much.

Dr. Harris.

[The prepared statement of Dr. Metcalf follows:]

TESTIMONY OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

BEFORE THE SUBCOMMITTEE ON HEALTH SENATE COMMITTEE ON FINANCE

CONCERNING

PAYMENT FOR PHYSICIAN SERVICES UNDER MEDICARE

Presented By

Harry L. Metcalf, M.D.

Chairman, Board of Directors

April 25, 1986

My name is Harry L. Metcalf, M.D. I am a practicing family physician from Williamsville, New York, and currently serve as Chairman of the Board of Directors of the American Academy of Family Physicians. I appreciate the opportunity to discuss with you payment for physician services under the Medicare program.

The American Academy of Family Physicians is the national medical specialty society with a membership of some 57,000 family physicians, including residents and medical students. Because family physicians are trained to treat the entire family, regardless of age, sex or health condition in the context of the family and total environment, family physicians are providing care to a significant segment of the Medicare population and will continue to do so at an increasing rate, as the age of their patients increases.

Of the approximately 35,000 active members of the organization in 1985, 93.3 percent report that they are in direct patient care, with 91.6 percent of that number in office-based practice. Of those in office-based direct patient care, 47.0 percent are in solo practice, 25.2 percent in a family practice group, 12.5 percent in a multi-specialty group and 14.4 percent in a two person partnership.

The above statistics illustrate that Academy members are in the forefront of the provision of direct patient care to the American public. Medicare payment policies impact directly and significantly on family physicians practicing throughout the country. This organization therefore is deeply concerned that changes in Medicare be crafted carefully with attention given to the impact on the health care delivery system, as well as to budgetary considerations.

The American Academy of Family Physicians, along with most of organized medicine, historically has supported the current Medicare reimbursement system based on customary, prevailing and reasonable charges. However, it has become apparent in the years since the inception of the Medicare program that significant reimbursement inequities are built into the existing system, inequities which are detrimental to family physicians and their patients. For this reason, the AAFP recognizes that modifications in the current Medicare reimbursement system, perhaps including the elimination of the CPR methodology, are needed to address these inequities.

Specifically, this organization is concerned about the significant payment differentials between physicians cognitive and procedural services, between physicians of different specialties providing similar services, and between rural and urban areas. The existing reimbursement system discourages the type of care it should be encouraging--preventive, comprehensive, ambulatory-based care--while rewarding procedurally-oriented, inpatient, episodic care.

These reimbursement inequities have been exacerbated through the imposition and continuation of the Medicare physician fee freeze. We would note that this program freezes the fees of those physicians providing cost-effective care and being reimbursed at low rates along with the higher fees of the more procedurally oriented specialists.

In view of recent statements by the Administration which advocate continuation of the present CPR reimbursement system until a capitation system can be developed for the Medicare program, this organization urges the Congress to consider making adjustments in the current system to address the above noted payment distortions.

Whether or not a capitation system comes to fruition, or Medicare is restructured in some other way, we would emphasize the necessity of addressing problems inherent in the current system to avoid making the same mistakes in developing new systems which may rely on historical data as was the case with the hospital prospective payment system.

In the Deficit Reduction Act of 1984 Congress called upon the Office of Technology Assessment to develop options for addressing these payment inequities. The report has been released indicating that such inequities do exist. Congressional concern, as evidenced in action calling for a report, is clear. However, what is not clear to the AAFP is whether action will be taken to correct the problems.

The Medicare physician fee freeze:

The Medicare physician fee freeze and "participating physician" program was imposed by Congress initially for a 15-month period scheduled to end in September 1985. Family physicians have been particularly hard hit by the freeze because it locks exisiting reimbursement inequities into the system. We have been told by many of our members that because they are locked into such reimbursement levels they cannot accept Medicare assignment.

It is no coincidence that the specialists with the highest incomes tend to have the highest "participation rate," as the pay freeze has different implications for different specialties. Figures recently released by the Health Care Financing Administration indicate that 27.9% of all physicians participating in the Medicare program have signed agreements to become participating physicians. The participation rate for "general practitioners" is shown as 23.6% and the rate is 27.1% for family physicians compared, for example, to 39.5% for radiologists and 46.2% for nephrologists. This should not be surprising given the fact that data provided by the AMA Socioeconomic Monitoring Service indicate the net income for surgical and medical specialties increased by 9.6% and 4.8% respectively between 1982 and 1983, while it decreased by 4.7% for family physicians/general practitioners.

Data from Medical Economics (February 1986) notes that from 1980 to 1985, the inflation rate as measured by the CPI rose 37%. The article further states that the median annual net income for family physicians rose only 13% during that same time frame, while that of other physician specialists increased to a much greater extent (19% for internists, 25% for pediatricians and 37% for cardiologists). Medical Economics further reports that the already high overhead expenses of family practice have increased from 43 to 48% of gross income from 1980 to 1985, while that of other specialists was lower and increased by a smaller percentage, such as neurologists, whose overhead increased from 30 to 34% of gross. While Congress and the Administration are considering various means of revising Medicare reimbursement, we would urge consideration of approaches other than fee freezes.

Reimbursement for physicians cognitive services:
The American Academy of Family Physicians, the American Society of Internal Medicine, and others have long been supportive of reimbursement reform that would address payment for physicians cognitive services. Cognitive services are integral to the practice of family physicians, yet are not recognized through the reimbursement mechanism. We would note that cognitive services are primarily office visits provided on a ambulatory basis. The OTA physician payment report notes that "within the office, the lack of payment for such primary care services as history taking or nutritional counseling contrasts sharply with the additional income that can be generated from, for example, providing laboratory tests, interpreting as electrocardiogram, or performing an endoscopy."

Specialty differentials:
Through mechanisms such as the delineation of hospital privileges, medicine has recognized that different specialists do provide similar services to patients. The Medicare program recognizes and promotes the establishment of differential prevailing fees for the same service based on physician specialty. Generally, this results in family physicians receiving less reimbursement than other specialists providing the same service. We would encourage the Congress to consider the elimination of such specialty differentials and rather, mandate that Medicare pay the same fee for a service without respect to the specialty designation of the physician providing the service.

Geographic differentials:

A similar case can be made for services provided by physicians in different geographic localities. Presently Medicare reimburses physicians in rural areas at a lower rate than those in urban areas. However, physician overhead costs, such as office equipment, do not justify the payment differential. We would contend that a payment equilibrium between urban and rural areas would provide encouragement for physicians to practice in those areas, thus improving access to care for the patients residing in rural areas, including Medicare patients.

Revision of the Medicare Economic Index:

A modification in Medicare physician payment proposed in the Administration's Budget would reduce the Medicare economic index (MEI) to take into account a revision of housing cost estimates. The Academy is deeply concerned about the impact on family physicians of the proposed reduction in prevailing charge limits which would occur if the current method of calculating the MEI is replaced and the values reweighted from 1974. Reimbursement for services of family physicians already is low due to the bias toward inpatient and procedurally oriented care and against ambulatory and preventive care services. An adjustment to the MEI which would result in a freeze on or lowering of Medicare reimbursement would increase the inequities already inherent in Medicare reimbursement.

The recently released report of the Office of Technology Assessment, "Payment for Physician Services" confirms that the approved charges of family physicians, general practitioners and internists have been most constrained by prevailing charge limits. Additional reductions in the prevailing charge limits, such as those proposed by the Administration, will further penalize those physicians already receiving low reimbursement because of this imbalance in Medicare payment policy.

Limitations of Reasonable Charges:
Administration efforts to restrain physician payment which do not acknowledge and address current distortions in Medicare physician payment policies are troublesome to this organization. A case in point is the implementation of a proposal in the budget calling for reductions in payments for procedures which are overpriced because of technological or productivity advances or because of geographic variations. We agree that there are inequities in the Medicare reimbursement methodology which result in excessive reimbursement for some procedures. However, inequities also result in deficient reimbursement. Yet the Administration, in regulations proposed to establish reasonable charge limitations, notes that "situations in which the reasonable charge mechanism results in a significantly deficient amount are virtually nonexistent." In reflecting on the proposals of the Administration to address excessive Medicare payments, we would urge Congress to consider all payment distortions--the excessively low as well as the excessively high.

Options for Medicare payment reform:
Various options for reform of Medicare reimbursement are currently under study by governmental and private organizations. Some

of these payment options include physician DRGs, relative value scales which are charge based, relative value scales which are resource cost based, capitation systems, etc. The AAFP believes that Congress should carefully evaluate these various studies prior to making sweeping changes in Medicare reimbursement policy.

Various medical organizations are advocating a relative value approach as the best means of addressing inequities in the current Medicare reimbursement system, particularly the differential between cognitive and procedural services. The Academy concurs that this approach merits serious consideration as an option to the current system. We would encourage Congress to monitor the relative value scales development project being conducted by Harvard University under the auspices of the Health Care Financing Administration, and which includes involvement of the physician community through the American Medical Association. The federal investment in this reimbursement project will be realized only if the results are studied prior to the mandating of major physician payment reforms.

In testimony before this Subcommitee, the Administration announced it believes "the only approach which addresses both price and utilization/intensity of services is capitation" (Statement of Henry Desmarais, M.D., HCFA, December 6, 1985). The American Academy of Family Physicians urges the Congress to carefully monitor HCFA evaluation of ongoing research in the area of physician reimbursement to ensure that such evaluation is not biased against methods other than capitation. We do not believe that current information supports the conclusion that one particular methodology is a panacea for the myriad problems with the Medicare reimbursement system.

Alternative delivery system:
Another way to look at Medicare reimbursement is to study the various payment alternatives that are being experiemented with in the private sector and through Medicaid demonstration projects. Among active Academy members, 16.6 percent are practicing in HMOs, 9.7 percent in IPAs, 9.8 percent in PPOs, 3.2 percent in hospital satellite clinics and 3.8 percent in freestanding emergency clinics.

Many members of the AAFP are negotiating with insurors in view of the effort to utilize preferred provider organizations as a cost savings mechanism. To respond to its members needs, the AAFP currently is developing model guidelines for a case manager system utilizing family physicians, and providing guidance for working with insurors in the various localities. While not endorsing the case manager concept as the singularly most effective approach for family physicians and their patients, the Academy is making every effort to respond to needs of its members who choose this particular mode of practice. The Congress may which to consider this as an option for Medicare reform.

In conclusion, the American Academy of Family Physicians appreciates the efforts of this Subcommittee to study the options for reform of Medicare reimbursement for physician services. We look forward to continuing to work with you to make improvements in this program which is so crucial to the health of Medicare beneficiaries throughout the country.

STATEMENT OF T. REGINALD HARRIS, M.D., PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE, SHELBY, NC

Dr. **Harris**. Thank you, Mr. Chairman.

My name is Reggie Harris. I am an internist in private practice in Shelby, NC, and president of the American Society of Internal Medicine. With me is Bob Doherty, ASIM's vice president of government affairs and public policy.

ASIM strongly urges Congress to acknowledge as an overriding principle that no single system of payment, whether it is capitation, fee-for-service, or some other variation, can meet all of the needs in this country. This society strongly supports a pluralistic system which offers patients, physicians, and purchasers a wide variety of acceptable payment alternatives.

Although ASIM believes that fee-for-service plans should continue to be an option for patients, we recognize that such payment methods can be and should be improved to reduce incentives for high cost technology and overutilization, to minimize inappropriate geographic differences in fees and practice patterns, to appropriately reduce fragmentation of billed services, and to protect patients from excessive out-of-pocket expenses.

Some of these changes can best be facilitated by legislation, and others more properly should be undertaken by the private sector.

ASIM commends Senators Dole, Durenberger, and Bentsen on taking the initiative to introduce legislation that would promote constructive long-term change in the system of payment for physician services. Such long-term reform is far preferable to continuation of arbitrary, budget-driven cuts in Medicare payments.

Based on a preliminary evaluation, ASIM believes that the direction of this bill is appropriate. It recognizes that improvements in fee-for-service payments under Medicare are needed, notwithstanding any future decision on capitation.

We believe the bill's language relating to the development of a relative value scale can be improved in several important aspects:

One, implementation, as well as development, of a resource-based RVS as a basis for determining patient levels should be mandated. A reasonable and realistic timetable for phasing in the new RVS should be established.

Two, the bill should mandate resource factors upon which relative values and payment levels will be based. Although the legislation requires the Secretary to consider, among other items, resource-cost factors in constructing the RVS, the importance of these factors in weighting various physician services is left to the Secretary's discretion.

Without such a strong mandate from Congress, it is possible and perhaps even likely that the Secretary will recommend that a resource-based RVS not be implemented, given the administration's apparent preference for capitation, or that any RVS developed under these provisions primarily will be a vehicle for reducing expenditures for overvalued services without increasing payment for undervalued services. This result would fall far short of the objective of bringing about a more rational and equitable approach to determining payments for physician services under Medicare.

The provisions in the bill relating to the use of the inherently reasonable criteria are a clear improvement over the administration's regulatory proposal. ASIM believes they can be further strengthened by incorporating some of the additional safeguards discussed in our written statement, including:

One, an expansion of the Physician Payment Review Commission's role in identifying services that are priced at a level that is too low or too high to be considered reasonable, and

Two, a specific mandate that inherent reasonableness authority be used to adjust payments for undervalued as well as overvalued services.

Finally, ASIM is disappointed that the bill simply phases in over 2 years a Medicare economic index recalibration. ASIM strongly opposes this disguised continuation of the fee freeze. Congress should reject the administration's proposal or at least provide some protection for undervalued cognitive services that would be disproportionately hurt by the proposed recalibration.

ASIM will be consulting with the American Association of Retired Persons, the American Academy of Family Physicians, and other appropriate groups in developing further recommendations on improving this proposal, to assure that it truly has the desired effect of correcting inequities in the current system of payment, particularly for physicians' cognitive and procedural services.

I am pleased to try to answer any questions from the committee.

Senator DURENBERGER. Thank you.

Dr. McGrath.

[Dr. Harris' prepared testimony follows:]

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STATEMENT

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE

SENATE FINANCE COMMITTEE

ON

PAYMENT FOR PHYSICIAN SERVICES UNDER MEDICARE

APRIL 25, 1986

american society of internal medicine
1101 VERMONT AVENUE NW·SUITE 500
WASHINGTON, DC 20005-3547·(202) 289-1700

Introduction

My name is T. Reginald Harris, MD. I am an internist in private practice in Shelby, North Carolina, and President of the American Society of Internal Medicine (ASIM). I appreciate the opportunity to express the views of internists throughout the country on alternative payment methods for physician services under the Medicare program.

In the years since ASIM was founded in 1956, the Society has played a leading role within the medical profession in studying and formulating innovative approaches to paying for physician services. During the past five years, in particular, the Society has devoted considerable time and resources to identifying the problems in the current system of payment for physician services--and developing constructive proposals to address and resolve those problems. In this process, ASIM has developed specific objectives and principles on payment for physician services that could serve as a basis for legislation to alter the current system of payment under the Medicare program. We are pleased to share with you now the current state of ASIM's thinking on this subject--as well as on specific FY 1987 budget proposals affecting payment for physician services.

Objectives of Payment Reform

In considering legislation to revise the system of payment under the Medicare program, ASIM strongly urges Congress to acknowledge, as an overriding principle, that no single system of payment--whether it is capitation, fee for service, or some other variation--can meet the needs of all individuals in this country. The Society strongly supports a pluralistic system, which offers patients, physicians, and purchasers a wide variety of acceptable payment alternatives. Legislation that mandates an exclusive system of payment, on the other hand, will be unacceptable to large segments of the American population, since it will limit the ability of patients, physicians, and purchasers to determine the kind of payment system that best meets their particular needs. An exclusive system of payment would also eliminate the advantages that accrue from allowing alternative methods to compete on the basis of quality, availability, and price.

Moreover, it is extremely difficult--perhaps even impossible--to predict the outcome for cost, quality, patient satisfaction, and availability, of any new system of payment particularly for the Medicare population, which has very limited experience with capitated systems of payment. Despite some of the problems with fee-for-service, the experience over the last 20 years shows that from a quality and availability standard, it has well served the needs of Medicare patients. Maintaining an improved fee-for-service system--while offering capitation as an option--would allow patients and physicians to opt out of any system that has unanticipated adverse outcomes. An exclusive system of payment would not allow such choice.

ASIM is concerned that statements from Administration officials and certain members of Congress favor an exclusive system using capitation as the sole payment method. The Society urges the Senate Finance Committee to reject the notion that there is a single answer to the problems with the existing system of payment under the Medicare program.

Instead, ASIM believes that Congress should promote a system that offers individuals a wide range of payment alternatives. Specifically, ASIM supports:

1. Expansion of the Medicare voucher system, with appropriate safeguards for patients, in such a way as to broaden the types of insurance plans that might be purchased by beneficiaries as an alternative to the traditional Medicare program.

2. Identifying both the strengths and the weaknesses of the capitation and fee-for-service models of payment, and making appropriate improvements in both. For fee-for-service, this means changing the existing incentives that may encourage excessive utilization, fragmentation of services, and overuse of technology. For capitation, this means assuring appropriate safeguards are in place to protect patients from incentives that encourage underprovision of necessary services. Powerful incentives under either system that encourage either overutilization or underutilization must be avoided.

Improving and Maintaining Fee for Service as an Option Under the Medicare Program

As noted earlier, ASIM firmly believes that fee-for-service must remain an option under the Medicare program and other insurance plans. The experience in the private sector when employees are offered a choice of fee-for-service or capitated plans suggests that many individuals continue to prefer fee-for-service, even though capitated plans such as health maintenance organizations (HMOs) are growing in numbers. From 1974 to 1984, the number of HMOs increased from 142 to 339. Enrollment, however, increased from 4.3 million individuals in 1974 to 17.0 million in 1984—which suggests that even though it has been federal policy for the last ten years to encourage enrollment in HMOs, the vast majority of individuals and purchasers have opted to remain with a fee-for-service plan.

Although it can be expected that enrollment in capitated plans will continue to increase, it is highly questionable whether the American people would want capitation to be the only choice available to them.

ASIM recognizes, however, that fee-for-service--particularly as distorted by the customary, prevailing, and reasonable charge methodology--can and should be improved. Specifically, proposals to improve fee-for-service should have the following goals:

1. Changing the incentives that encourage high cost technology at the expense of personalized, time-consuming caring services by physicians.

2. Protecting beneficiaries and the Medicare program from overutilization of services that may occur because of incentives existing under the "customary, prevailing and reasonable" charge system.

3. Minimizing inappropriate geographic differences in the fees charge for certain services, while maintaining enough flexibility to permit appropriate variations in fees and allowances based on legitimate differences in the cost of practice by geographic region.

4. Developing a more effective means of protecting beneficiaries from aberant or excessive fees charged by some physicians.

5. Identifying ways to disseminate information on inappropriate geographic variations in practice patterns, as a way of modifying physicians' practice patterns over time. Research suggests that physician education through dissemination of information on practice variations is the most effective means of modifying physician behavior.

6. Protecting low income beneficiaries from excessive out of pocket costs, through appropriate incentives to accept Medicare assignment on an individual claim-by-claim basis.

7. Developing equitable and fair ways to address the potential for "fragmentation" of services that may exist under the current a la carte billing and coding system. Congress should exercise caution, however, in mandating any untried packaging scheme--such as DRGs for physicians or ambulatory visit encouters--that may have unanticipated adverse effects on patient care.

To address these problems in an constructive manner, ASIM favors the following mix of public and private sector initiatives:

1. Congress should mandate the development and implementation within a reasonable period of time, of a new system of payment consisting of a schedule of allowances based on a resource cost relative value scale, in lieu of the existing "customary, prevailing and reasonable charge" system. The Health Care Financing Administration (HCFA) recently awarded a contract to Harvard University to develop a resource based relative value scale. This project provides a means for developing a consensus on more appropriate relative values for physician services, based on the amount of time required to

provide the service; the complexity of the service; physicians' investments in professional training and education; overhead factors; liability risks; and other appropriate resource cost factors that may be identified through this study. Although HCFA has agreed to fund this project, ASIM is concerned that the Administration's apparent preference for an exclusive system of capitation may result in a decision not to implement the results of the Harvard project, or to discontinue funding prior to completion of the study. Therefore, ASIM favors a specific mandate from Congress that would require completion and implementation of a resource cost relative value scale by a defined date.

Although the COBRA legislation requiring a study by DHHS of relative values, and the Dole-Durenberger-Bentsen bill on physician payment reform are steps in the right direction, ASIM believes a stronger and more specific mandate is needed. The Society's specific comments on the Dole-Durenberger-Bentsen initiative are discussed later in this statement.

A relative value scale based on resource costs would help accomplish two of the goals identified above: altering incentives for high cost technology and protecting patients from overutilization of services. Under the existing "charge based" payment system under Medicare, an irrational system has evolved that is having a negative influence on the care Americans receive today Distortions in the relative valuations of cognitive and procedural services have created financial disincentives and likely contribute to the public perception that medicine today is too costly, inefficient and impersonal.

Cognitive services--a term which describes the processes of problem solving; applying diagnostic skills of comprehensive history and physical examinations;

data collection and analysis; therapeutic assessment and case management; patient and family counseling; and ongoing compassionate care of patients--have always been paid for at lower rates than technical services. Health insurance was originally created to protect patients from the high cost of hospitalization and later, from the cost of surgery. Benefits were later expanded to cover procedural services, such as laboratory tests. Since charges for cognitive services were not covered, they remained low so as not to produce serious strain on the family budget. Physicians, finding that diagnostic and therapeutic assessments were not covered, also began to place more emphasis on charging separately for laboratory tests, ancillary procedures, and other covered services. In marketing terms, the office visit became an unconscious "loss leader." This disparity continues today: a 1979 study funded by the Health Care Financing Administration--and a more recent study funded by the Massachusetts State Rate Setting Commission--found that cognitive services such as office visits are undervalued by a factor between two and three to one compared to surgical procedures.

As a result of this distortion in the relative values of cognitive and procedural services, a physician who orders or performs an expensive array of technology-intensive services is well compensated. A physician who spends time with a patient, carefully assessing his or her need for further tests and procedures, is penalized for that style of practice. Logic and research both tell us that reducing incentives to provide technology intensive care will result in fewer tests being ordered, fewer procedures being performed, and in all probability, fewer instances of hospitalization. This conclusion is supported by a large body of expert opinion and research. ASIM will be pleased to share with the Committee some of the literature that supports this view.

A resource cost payment system--by placing more reward on time consuming, complex "cognitive services" in comparison to technical procedures--would be a major step toward reducing incentives for overutilization of high cost technology, thus making fee-for-service under Medicare a far more cost effective payment option than is now the case.

2. Conversion factors applied to a resource cost relative value scale to create a schedule of allowances should vary appropriately according to an index that accurately reflects differences in the current costs of practice in various parts of the country. Once a resource based relative value scale is developed, it will be a fairly simply matter for the Medicare program to determine the appropriate conversion factors--based on budgetary and fiscal objectives among other factors--for each service including in the RVS. Since a resource based RVS will reflect differences in the time and complexity of various services, it will not be necessary to differentiate by specialty in determining conversion factors. Geographic differences in payment levels, however, may be appropriate, but only to the extent that such differentials can be justified by legitimate differences in the cost of practice in difference parts of the country. Under a schedule of allowances based on a relative value scale, legitimate differences in the cost of practice can be recognized by allowing different conversion factors for different parts of the country. The schedule of allowances could then be updated each year to reflect changes in the cost of practice, according to a new cost of practice index that accurately reflects changes by locality in practice costs. The existing Medicare Economic Index is not suitable for this purpose, since it does not differentiate by locality in measuring costs, nor does it accurately reflect the true practice costs incurred

by physicians. HCFA should be required to consult with physician organizations in developing a new cost of practice index that can be used to allow appropriate regional adjustments in conversion factors to reflect legitimate differences in the cost of practice.

3. There should be an opportunity for physicians to negotiate with a local Medicare intermediary for a more appropriate conversion factor, if there are grounds to believe that the conversion factor determined by HCFA fails to recognize some legitimate differences in practice costs in that region or locality. ASIM believes that the opportunity to negotiate over conversion factors is desirable, since it is likely that any conversion factor determined solely by HCFA according to a mathematical formula may, in some cases, fail to reflect some legitimate practice cost differences. Moreover, HCFA's track record of failing to follow through on promised updates in Medicare reimbursement suggests that updates in conversion factors may be arbitrarily limited for budget reasons. Providing some legal basis for physicians to negotiate, through their state medical societies or other entities, over conversion factors would provide a fallback for physicians and beneficiaries in the event that conversion factors calculated by HCFA, for budgetary or other reasons, are inequitable.

4. The resource based relative value scale should be updated on an annual basis as new procedures enter the system. The overall relative value scale should be reevaluated at three year intervals to reflect changes in the resource cost required to perform certain services. Conversion factors should be updated

annually to reflect changes in the cost of practice index. This will assure that relative values and payment levels reflect changes in the cost of practice, technology, complexity of services, and other factors.

5. Once a resource based relative value scale is developed, the new schedule of allowances based on resource costs should be phased in as rapidly as feasible (i.e., over a three year period to allow time for physicians and patients to adapt to the new payment schedule).

6. Physicians should continue to have the right the establish their own fees and either accept--or not to accept--the amount of payment identified by the schedule of allowances. An indemnity system of this type will allow patients to shop around for those physicians whose charges are competitive with the amount allowed under the schedule of allowance. ASIM believes that the existing claim-by-claim assignment option, in general, has served the interests of both beneficiaries and the Medicare program. Statistics by the Health Care Financing Administration show that acceptance of assignment is at an all time high. In addition, several studies demonstrate that physicians generally accept assignment on older, sicker, and poorer beneficiaries. Therefore, mandatory assignment clearly is unnecessary. Moreover, mandating acceptance of assignment will undermine physician support for the Medicare program, reduce availability of services to beneficiaries, result in cost shifting to non-Medicare patients, inhibit price competitiveness, and distort the doctor-patient relationship. ASIM believes that it is appropriate, however, to explore incentives to encourage physicians to accept assignment within the current

individual assignment option. ASIM will be developing recommendations to encourage acceptance of assignment on an individual claim basis, and will be pleased to share with Congress those recommendations as soon as they are available.

7. Physicians should advise patients in advance of rendering services, whenever possible, of the fees charged for that service, as well as on whether or not assignment will be accepted. ASIM has publicly urged its entire membership to discuss fees and assignment policies with beneficiaries in advance of rendering services. Although the fee charged for a service does not necessarily predict the total cost of care (since cost is a function of both the fee for the service and the number of services ordered), providing fee information to patients in advance of rendering services will allow individual beneficiaries to select a physician whose fees are competitive with Medicare's schedule of allowances.

8. The medical profession, in cooperation with HCFA and other third party payors, should develop a more effective system for addressing the problems created by the minority of physicians who charge excessive or aberant fees, or who order services unnecessarily in order to increase practice revenue. ASIM believes that although local fee review committees in some localities have been relatively effective, a more national approach to this problem is needed. In addition, antitrust concerns that limit the ability of professional organizations to discipline physicians must be addressed in any proposal to improve peer review of excessive fees and practice patterns. ASIM will be exploring with HCFA, other third party payors and the American Medical Association more effective ways of strengthening peer review of excessive fees and practice patterns. An effective program to review aberant fees and

practice patterns--coupled with dissemination of fee information in advance of rendering services and developing appropriate incentives to accept assignment on a claim-by-claim basis--would accomplish the goal of protecting beneficiaries from excessive out of pocket expenses, without resorting to mandatory assignment.

9. The medical profession should develop programs to disseminate information on medical practice variations to physicians, as a means of encouraging appropriate changes in styles of practice. In some instances, geographic variations in practice patterns may be justifiable. For example, a community with the lowest utilization patterns may not necessarily be providing as high quality of care as a more expensive community. Differences in pattern patterns might also be explained by the availability of certain innovative forms of technology in some communities compared to others. In general, however, ASIM believes that variations in practice patterns that cannot be explained by such factors may not be justifiable or necessary. Recent research supports the conclusion, however, that the most effective way of changing inappropriate practice patterns is to develop a reliable method of data collection and analysis and dissemination of such data to physicians. Once physicians are aware of inappropriate variations in practice patterns by locality, physicians naturally tend to take corrective action. ASIM is working on the development of a program to collect and disseminate data on practice variations to internists. The Society understands that the AMA and many state medical societies are developing similar programs. Given the response of the private sector to this problem, ASIM does not believe that legislation to address

practice variations is needed at this time, except perhaps in the form of making grant money available to medical and other organizations to develop appropriate data collection and dissemination programs.

10. Physicians and payors should explore equitable, fair and appropriate ways of "bundling" or "packaging" services to minimize the fragmentation of billed services that may occur under the existing "a la carte" billing and coding system. ASIM will be developing recommendations on appropriate ways of "packaging" physician services under a fee-for-service system. The Society cautions Congress, however, not to rush into any particular scheme for "bundling" services, such as ambulatory visit packages that include reimbursement for all ancillary services in a set payment for a patient encounter, until more research and discussion takes place on the most appropriate way to "package" or "bundle" services. Packaging of services, if not done correctly, could result in incentives for underutilization of services.

ASIM believes that improvements in the fee-for-service system, as described above, would assure that fee-for-service remains a viable and cost effective option for patients who are Medicare beneficiaries. Some of these changes can best be facilitated by legislation; others more properly should be undertaken by the private sector. ASIM welcomes the opportunity to work with the Committee on developing an appropriate legislative proposal that includes those elements identified above that most appropriately can be facilitated through legislation.

Evaluation of the Dole-Durenberger-Bentsen Initiative

ASIM commends Senators Dole, Durenberger and Bentsen on taking the initiative to introduce legislation that would promote constructive, long-term change in the system of payment for physician services. Such long-term reform is far preferable to continuation of arbitrary, budget driven cuts in Medicare payments. Because of time constraints, the Society has not yet had the opportunity to review the draft proposal in great detail. Following further evaluation, the Society expects to have some more specific recommendations to offer the sponsors and the Senate Finance Committee.

Based on a preliminary evaluation, however, ASIM believes that direction of the bill is appropriate; it recognizes that improvements in fee-for-service payment under Medicare are needed, notwithstanding any future decision on capitation. Moreover, ASIM particularly is pleased that the bill (1) expresses a preference for a resource based relative value scale approach (building and expanding on the COBRA provision); (2) recognizes that many services are undervalued--as well as overvalued--under the existing system of payment; and (3) incorporates provisions intended to improve the administration's budget related proposals affecting payment for physician services under Medicare.

The Society believes, however, that the proposal should be strengthened by incorporating many of the elements described earlier on development of a resource-based RVS. Neither COBRA nor the new proposal mandate implementation of a resource based RVS. Nor do the proposals specifically require the Secretary to increase relative payments for undervalued cognitive services based on a resource cost relative value scale. Without such mandates, it is possible--perhaps even likely--that the Secretary will recommend that a resource based RVS not be implemented (given the Administration's apparent preference for capitation)--or that any RVS developed under these provisions primarily will be a vehicle for reducing expenditures for overvalued physician services, without increasing payments for undervalued services. This particularly may be the case since although the legislation requires the Secretary to "consider among other items" resource cost factors in constructing the RVS, the importance of these factors in weighting various physician services is left to the Secretary's discretion. Nowhere does the bill require the Secretary to base relative values and payment levels on time, complexity, overhead, risk, training, and other resource factors. Indeed, since it is conceivable that the Secretary may choose to give little or no weight to time and complexity factors, in constructing the RVS, the probability exists that DHHS will develop an RVS based primarily on historical charges, with recommended modifications limited only to reducing payments for selected "overvalued" services.

The fact that the proposed RVS is due no later than July 1, 1987, further increases the chances that the RVS will be based primarily on historical charging patterns, since it is highly unlikely that a true resource cost analysis for most physician services can be completed in a little over a year (the Harvard project, by comparison, projects a 30-month completion timetable).

ASIM is pleased, however, that the bill would require the Secretary to make adjustments in payments under a resource cost RVS based on a new cost of practice index, which would allow appropriate variations by geographic location. It is essential that the bill specify that such an index be developed in consultation with professional organizations.

The provisions in the bill relating to the use of "inherently reasonable" criteria are a clear improvement over the administration's regulatory proposal. ASIM believes that they can be further strengthened, however, by incorporating some of the additional safeguards discussed later in this statement under our discussion of the Administration's budget proposals. In particular, although ASIM welcomes the finding in the bill that some services may be paid at "grossly deficient" levels, the Society favors a stronger mandate that would require specific improvements in payment for undervalued cognitive services, rather than leaving this solely to the Secretary's discretion.

Finally, ASIM is disappointed that the bill simply phases in over two years the Medicare Economic Index recalibration. For the reasons explored in detail later in this statement, ASIM strongly opposes this disguised continuation of the fee freeze. Congress should reject the Administration's proposal--or at least provide some protection for undervalued cognitive services that would be disproportionately hurt by the proposed recalibration.

ASIM will be consulting with the American Association of Retired Persons, American Academy of Family Physicians, and other appropriate groups in developing further recommendations on improving this proposal, to assure that it truly has the desired effect of correcting inequities in the current system of payment, particularly for physicians' cognitive and procedural services.

Capitation as an Option Under the Medicare Program

ASIM supports the concept that patients who are Medicare beneficiaries should have a choice of a variety of payment methodologies, including HMOs and other plans that are paid a set amount per beneficiary (capitated). For this reason, the Society supports expansion of the current voucher system to enable beneficiaries to enroll in a wider variety of health insurance plans as an alternative to traditional Medicare coverage.

It must be recognized, however, that capitation systems may create incentives for underutilization of necessary services, if not designed properly, just as fee-for-service may have the opposite tendency to reward excess utilization. Therefore, ASIM believes that voucher legislation must:

A. Assure that beneficiary participation is entirely voluntary.

B. Require plans to offer, at a minimum, the full range of Medicare benefits.

C. Contain specific provisions requiring disclosure of the provider organization's rules, procedures, coverage, policies, and any other information necessary, for beneficiaries to make an informed choice;

D. Contain adequate safeguards against adverse and preferred risk selection.

E. Establish a mechanism for periodic monitoring of the program. ASIM specifically supports legislation to mandate that effective quality review systems be in place for assuring that appropriate care is provided by plans financed through capitation payments. Such quality review should be performed by a peer review group independent economically from the capitated plan. ASIM recommends that a national advisory committee be created to advise HCFA on quality review of capitated plans, with broad representation on the group of Medicare beneficiaries, physicians involved in capitation plans and peer review organizations, and physicians not directly affiliated or employed by a capitated insurance plan or a PRO.

F. The voucher amount must be set at a level that assures that incentives are not created to deny necessary care to enrolled patients who are Medicare beneficiaries. The Society is concerned that the automatic reductions required by Gram-Rudmann-Hollings on March 1, 1986, already has made it more difficult for some capitated plans to provide adequate care for the reduced voucher amount. ASIM is particularly concerned that the Health Care Financing Administration, for budgetary reasons, may continue to ratchet down on the voucher amount, with an adverse impact on the quality and availability of care provided to Medicare patients enrolled in these programs.

ASIM has reviewed the Administration's proposal to expand the existing Medicare voucher option. The Society is strongly concerned that the Administration proposal does not include adequate safeguards, as described above, and would welcome the opportunity to work with the committee in modifying the Administration's proposal.

ASIM strongly believes that voucher proposals, which make it possible for patients to voluntarily enroll in capitation plans, are far preferable to a geographic capitation model, which would pay an insurance plan or other fiscal intermediary a set amount per beneficiary per month in a given area of the country, thus making the capitation plan the exclusive choice available to beneficiaries in that locality. So far, the Reagan Administration and Congress have opted for the voluntary voucher approach. There is considerable interest, however, in pushing for a geographic capitation model in the future. The Health Care Financing Administration is currently considering setting up a prototype geographic capitation plan in Maryland as a demonstration project to test this approach prior to implementation in other parts of the country.

Under the proposed demonstration project, Blue Cross/Blue Shield would be paid a set amount to insure beneficiaries rather than only to administer the program in Maryland. HCFA would pay the plan a monthly amount based on the number of Medicare beneficiaries, with half of any profits going to the federal government and the other half divided equally between Blue Cross/Blue Shield and beneficiaries, who would receive a rebate. Blue Cross/Blue Shield proposes to offer several options to beneficiaries: traditional Medicare coverage, traditional health insurance, Blue Cross/Blue Shield sponsored HMOs, and a sponsored preferred provider organization (PPO).

Even though fee-for-service may continue to exist as a plan option under a geographic capitation model, ASIM believes that it is important to recognize that all care rendered to beneficiaries under a geographic capitation model will be at risk, by virtue of the fact that the fiscal intermediary has a strong incentive to control the use of services in order to profit under this model. Therefore, unlike voluntary voucher approaches that offer beneficiaries a choice of traditional (non-capitated) Medicare coverage or capitated plans, a geographic capitation model in essence makes capitation the only choice available to Medicare beneficiaries in a given area, notwithstanding the fact that some fee-for-service plans might be offered within the overall capitation system.

The exclusive nature of the geographic capitation approach greatly concerns ASIM. Despite some of the problems with a voluntary voucher approach, the element of choice is preserved: under a properly designed voucher system, beneficiaries that do not like the quality of care they are receiving under a capitated plan can, at their own option, enroll in traditional fee-for-service plans that do not contain the same incentives for underutilization of services. A beneficiary who lives in a state under a geographic capitation model would have no alternative if he or she does not like the quality of care that results from placing the fiscal intermediary at risk for all services.

In addition, the Society firmly believes that Congress and HCFA should carefully evaluate the experience of the existing voucher system on quality, availability, price and patient satisfaction before considering a mandatory capitation program, even on a demonstration project basis. Even the Office of Technology Assessment (OTA)--which apparently favors mandatory vouchers--acknowledges that "It is difficult to predict the implications of widespread capitation payment on the basis of financial incentives and past experience. Medicare enrollment in risk-sharing plans has only recently reached substantial numbers, mostly in demonstration projects that remain to be evaluated. And one cannot assure that new plans, which differ in size, sponsorship, organization, and risk sharing arrangements from the older, well-studied ones, will achieve similar results in cost, quality and access. Geographic capitation for Medicare beneficiaries is completely untried as yet . . ."

Finally, one of the arguments for geographic capitation and mandatory vouchers--that it gets the federal government out of the business of determining payment levels, assuring quality, etc.,--greatly concerns ASIM. Despite the problems that physicians and patients have with HCFA's administration of the program, the agency ultimately is accountable to Congress, and therefore, the public. Congress often serves as an "ombudsman" when patients and physicians experience problems with the program. Turning over to fiscal intermediaries the decisions over payment levels, methods of payment, benefits, and quality--subject only to very general and episodic oversight by HCFA and Congress--would weaken Congress' ombudsman role, and therefore, accountability to the public.

Therefore, ASIM strongly urges Congress to encourage a voluntary voucher system that gives beneficiaries the option of enrolling in capitated plans, rather than an exclusive geographic capitation system that provides beneficiaries with no option but to receive care under a system that contains strong incentives to underprovide services. For similar reasons, ASIM opposes a mandatory voucher system, the option apparently favored in a recent Office of Technology Assessment report on physician payment.

In the event that Congress does mandate a geographic capitation model--even on a demonstration project basis-ASIM believes that certain safeguards should be included to protect patients and physicians. Specifically, ASIM believes that any geographic capitation plan should include the following:

1. The federal government should require the fiscal intermediary to offer a managed fee-for-service program as an option to beneficiaries. Although any fee-for-service plan offered under a geographic capitation model ultimately falls under the incentives created by placing the intermediary at risk for all services, ASIM believes it is preferable that at least some fee-for-service plan be available to beneficiaries in the area. This will allow beneficiaries to continue to receive care from physicians who may be unwilling to contract with an HMO or other competitive medical plan.

2. The federal government should mandate that the fiscal intermediary use a resource cost relative value scale as a basis for creating schedules of

allowances under the fee-for-service options offered to physicians and beneficiaries. This would assure that any fee-for-service options offered by the intermediary include appropriate incentives to reward cognitive services, rather than high cost technological services.

3. The federal government should mandate that effective quality review systems be in place for assuring that appropriate care is provided by plans financed through capitation, including capitated fiscal intermediaries.

4. No fiscal intermediary should be eligible for a geographic capitation contract if its total Medicare and private business, when taken together, would give the intermediary a dominant market share in that geographic area that would effectively preclude competition from other insurers in that marketplace. ASIM is concerned that if Medicare awards a geographic capitation contract to an insurer that already controls much of the private insurance market, the result could be a virtual monopoly that would give the intermediary unprecedented influence over the medical marketplace. Such a result would make it difficult for physicians to stand up to the entity as an advocate for their patients. Further, it would greatly diminish physician and patient access to other systems.

5. The federal government should closely monitor profits received by intermediaries under a geographic capitation contract. Intermediaries should be required to share most of the profit with beneficiaries, in the form of improved services and benefits or reduced cost sharing.

6. The experiences of physicians, patients, and payors under a geographic capitation demonstration project should be closely evaluated and monitored before the program is expanded to any significant degree.

Comments on Specific Budget Proposals on Physician Reimbursement

Under the heading "selective physician reimbursement reform," the Administration proposes several regulatory initiatives designed to decrease spending on Medicare Part B services.

As noted earlier, the Administration specifically proposes to "recalibrate" the Medicare Economic Index--which limits increases in prevailing charges according to how much the Health Care Financing Administration (HCFA) has concluded overhead costs have increased since 1971--by lowering the housing component of the MEI. Although the Administration has not yet published a notice of how it plans to implement this budget item, it has been suggested that this will result in an increase in Medicare prevailing charges on January 1, 1987, of one percent or less.

ASIM believes the proposed recalibration of the MEI, in effect, is an indefinite continuation of the Medicare fee freeze. On March 1, 1985, all physicians--as a result of Gramm-Rudman--absorbed a one percent decrease in Medicare prevailing charges. Under the recently enacted Budget Reconciliation Act of 1985, the vast majority of physicians who have chosen to be "nonparticipating" will continue to have prevailing charges frozen at the June 30, 1984 level, minus this one percent reduction. Therefore an increase of one percent or less on January 1, 1987, will result in the prevailing charges for those physicians remaining at or below the June 1984 levels through December 31, 1987. This means, in effect, that prevailing charges for the vast majority of services rendered to Medicare patients (i.e., services rendered by nonparticipating physicians) will be paid at least through December 31, 1987, at the "actual charge" levels in effect in calendar year 1982. (This is because the June 30, 1984 prevailing charges were based on charges submitted during calendar year 1982, or earlier if the Medicare Economic Index applied.)

It is clear that a five-year gap between Medicare allowances and actual charges will create incentives to decrease the quality and availability of services to Medicare beneficiaries. During the past five years, physician overhead costs have increased measurably. From January 1982 through December 1984, the Consumer Price Index increased by 11.7 percent (all items) and by 14.5 percent (all services). From 1982 through 1985, physicians' average overhead costs increased by 18.1 percent.

Given the likelihood that physician practice costs will continue to increase at a steady rate, the proposed recalibration of the MEI is likely to mean that the rate of increase in Medicare prevailing charges will fall farther and farther below actual fees charged by physicians, actual increases in physicians' overhead costs, and payments by other third-party payors. In this respect, the Administration's proposal is worse than a congressionally mandated fee freeze, since it guarantees for the indefinite future that Medicare payments will not be realistic given what is actually occurring in the marketplace. Moreover, since the Administration proposes to do this administratively, Congress will have no direct opportunity to review whether or not this reduction in Medicare benefits serves the interests of beneficiaries.

Ultimately, a continued erosion in the value of Medicare benefits will force compromises in the quality and availability of services provided to patients who are Medicare beneficiaries. As prevailing charges continue to fall behind the actual cost of providing services, physicians will be faced with some difficult and unpalatable choices. One choice--already adopted by a large number of physicians--will be to move to a dual fee schedule: a higher fee schedule for private patients and a lower one for Medicare beneficiaries. This creates a clear danger that over time Medicare patients will be treated differently, and perhaps not as well, as non-Medicare patients.

A second potential response, equally unpalatable to most physicians, will be to close their doors to seeing any more Medicare patients than are currently being seen in their practices. Economic realities will dictate that those physicians with high Medicare patient loads will suffer disproportionately compared to those with younger, healthier patients insured by private insurance plans. A smaller number of physicians may decide not to treat Medicare patients at all. Either response--closing their doors to additional Medicare patients or dropping out of the program altogether--will create severe obstacles to the availability of high quality medical care for patients who are Medicare beneficiaries.

A third response will be to ask Medicare patients to pay more for their services directly out of pocket. Increased out-of-pocket costs might occur in several ways:

- Nonparticipating physicians may decrease the number of times they accept assignment on services rendered to Medicare patients, thus reversing the trend to date of increasing assignment rates.

- Physicians who are currently participating may revert to nonparticipating status, since the proposed recalibration of the Medicare Economic Index will apply to their services as well as to those rendered by nonparticipating physicians.

- Once the freeze expires, nonparticipating physicians may increase their actual charges to beneficiaries. On any unassigned claim, this would mean that the patient would be forced to pay more out of pocket to cover the gap between Medicare's payment and the actual charge.

A fourth response may be to decrease administrative services currently provided by physicians free of charge to Medicare patients. For example, many physician offices complete claims for all Medicare patients, regardless of whether or not the claim is assigned or unassigned. As overhead costs increase, however, physicians may be forced to reduce administrative staff and discontinue unessential administrative services that represent additional practice costs.

A fifth response may be to increase the quantity and complexity of services billed to the Medicare program. A recent study found that physician price controls are not effective in curbing increases in program costs, due to increases in the number of services provided and in the complexity of services (Rice, T.H. Reducing Public Expenditures for Physician Services: The Price of Paying Less).

Finally, a likely response to continuing a virtual freeze on Medicare payments--but one that will be most strongly resisted by the medical profession--will be to decrease the quality of services provided to patients who are Medicare beneficiaries. This may occur through subtle changes in practice patterns, such as spending relatively less time with Medicare patients compared to other patients. Or it may occur more directly, by declining to provide certain necessary services to Medicare patients if the payment levels do not cover the actual costs of providing the service.

Physicians strongly object to being placed in a position of being forced to make such choices, none of which are in the best interests of patients. The medical profession has already absorbed four years of increased costs with no increase in Medicare payments for their services, while managing to maintain the same standard of quality medical care expected by patients who are Medicare beneficiaries. At the same time, physicians have been able to increase assignment rates to all time high. It is unrealistic, however, to expect that physicians can indefinitely absorb the shortfall resulting from arbitrary limits on Medicare prevailing charges without changing the way that Medicare patients are treated.

For these reasons, ASIM strongly urges Congress to mandate legislatively that the Administration not proceed with its plans to recalibrate the Medicare Economic Index or to otherwise extend the existing fee freeze through regulation. Only a clear statement by Congress to this effect, ASIM believes, will be sufficient to prevent the Administration from implementing this dangerous proposal.

Moreover, physicians who provide primarily office based services--such as internists and family physicians--will be disproportionately harmed by an extension of the fee freeze under the guise of recalibrating the MEI. Cognitive services provided by office based physicians--such as office, nursing and home visits--have been hurt to a greater extent under the Medicare fee freeze than lower overhead procedural services. Traditionally, Medicare payment levels have undervalued cognitive services in comparison to procedures. This disparity has been demonstrated by numerous studies, including a 1979 study funded by the Health Care Financing Administration which concluded that a two- to three-fold disparity exists between payments for cognitive services and surgical procedures under the Medicare program (Hsaio and Stason, Toward Developing a Relative Value Scale for Medical and Surgical Services). This conclusion was reaffirmed by a more recent study in Massachusetts (Hsaio and Braun, Resource Based Relative Values of Selected Medical and Surgical Procedures in Massachusetts). Not coincidentally, office based physicians are also the ones that bare the greatest burden of increasing overhead costs. Therefore, ASIM strongly believes that Congress and the Administration should exempt office, nursing, and home visits from continued restrictions on increases in Medicare prevailing charges, such as a proposed MEI recalibration.

For example, one alternative might be to apply the proposed MEI recalibration only to inpatient services. ASIM believes, however, that although some relief for office-based cognitive services is essential, it is far preferable that Congress and the Administration impose no further across-the-board limits on Medicare payments for any physician services. If such limits are to be imposed, however, exempting selected cognitive services will at least minimize some of the harmful effects of this approach.

Reducing Payment for Services Priced at a Level That is Not "Inherently Unreasonable"

The Administration also has proposed, by regulation, to reduce payment for services that are priced at a level that is determined to be "inherently unreasonable."

Since 1983, ASIM has supported the concept that charges and allowances for new procedures should reflect changes over time in the resource costs, (such as expertise, time, liability risks, special training and development costs) required of physicians performing a service, and has urged members to adopt this principle in establishing charges for procedural services. ASIM supports reasonable and fair approaches to accomplish this objective.

ASIM, however, is strongly concerned that the Administration's approach may result in "inherently reasonable" determinations driven strictly by budget concerns, with insufficient attention to the effects of revised payment rates on beneficiaries. For this reason, ASIM has urged the Administration to withdraw its recent notice of proposed rulemaking (NPRM), as well as Transmittal 1115 which instructs carriers on local application of the inherently reasonable criteria. ASIM believes that a new notice of proposed rulemaking should be published only after the Administration has had adequate consultation with representative physician, beneficiaries and members of Congress on application of the inherently reasonable criteria, and only after major modifications are made in the Administration's approach to this issue.

There is also considerable question whether or not the Administration, under current statute, has the authority to proceed with promulgating this regulatory initiative. Therefore, ASIM believes that Congress must clearly state its intent that HCFA and local carriers not proceed with use of the "inherently reasonable" criteria to reduce payment levels, unless some strong safeguards are included in the process. Specifically, HCFA should be required to:

- Consult on an ongoing basis with an appropriate physician group in determining how inherent reasonableness should be applied to specific procedures. For example, Congress could require HCFA to consult with the Physician Payment Review Commission, recently enacted by Congress, on any proposed "inherent reasonableness" determination. Although Dole-Durenberger-Bentsen would require the Commission to comment on specific published regulatory determinations under "inherent reasonableness," ASIM believes that the role of the Commission should be strengthened to require consultation with the Commission before a determination is made by the Secretary.

- Develop an appropriate formula to allow legitimate adjustments in proposed national fee schedules or caps on payment based on quantifiable differences by locality by the cost of practice. The MEI is not suitable for this purpose, since it does not differentiate in practice costs by locality, nor does it accurately reflect the true practice costs incurred by physicians. HCFA should be required to consult with physician organizations in developing the new formula.

- Make available for public review and comment the reasons why it was determined that a procedure was overvalued or undervalued and the data used to make the determination. ASIM is pleased that this requirement is included in draft Dole-Durenberger-Bentsen proposal.

- Use inherently reasonable criteria to adjust payment for undervalued, as well as overvalued, services. As noted earlier, ASIM favors the incorporation into Dole-Durenberger-Bentsen of a stronger mandate to this effect.

- Mandate the establishment by carriers of physician advisory groups to provide ongoing input on inherently reasonable determinations on the local level.

- Require carriers to make available for public review and comment the reasons and data behind an inherently reasonable determination with a sufficient specified comment (minimum 90 days).

- Describe in any future NPRM any other criteria, procedures, etc. to be used by carriers in making inherently reasonable determinations.

- Require carriers to make payment changes for services determined to be undervalued, as well as those determined to be overvalued.

The draft Dole-Durenberger-Bentsen bill should include specific requirements relating to use of inherent reasonableness by carriers, as well as by HCFA.

ASIM believes that only with substantial changes of this nature can physicians and beneficiaries be assured that inherently reasonable determinations will be made on a fair and rational basis, rather than strictly to reduce programmatic expenditures. The Society is concerned that the Administration will not, on its own, make satisfactory changes in its approach to this issue in any future proposed or final regulations governing use of inherently reasonable by HCFA and its carriers. Therefore, given the considerable uncertainty whether or not HCFA even has the authority to promulgate this regulation, ASIM believes that Congress must clearly express its intent that any statutory authority to make "inherent reasonableness" determinations is contingent upon incorporating sufficient safeguards into the process, as described above. Dole-Durenberger-Bentsen, although a step in the right direction, should be strengthened to include those specific elements discussed above not already addressed in the bill.

Conclusion

ASIM appreciates the opportunity to share with the committee its views on reform of Medicare system of payment for physician services. The Society supports appropriate legislation to facilitate improvements in a fee-for-service and capitation models, and to expand the access of patients who are Medicare beneficiaries to a wide variety of payment options. The Society strongly urges Congress, however, not to mandate an exclusive system of payment for all services rendered to Medicare patients.

ASIM will be sharing with the Committee in the near future additional recommendations for strengthening the Dole-Durenberger-Bentsen proposal on payment for physician services.

I am pleased to try to answer any questions from the committee.

/srl

G-BD-0385

STATEMENT OF JOHN McGRATH, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN PSYCHIATRIC ASSOCIATION, WASHINGTON, DC

Dr. McGRATH. Mr. Chairman, I am Dr. John McGrath, a physician in the private practice of psychiatry in Washington, DC, and a member of the board of trustees of the American Psychiatric Association, representing over 32,000 physician-psychiatrists nationwide.

We are pleased to have the opportunity to provide our views about physician payment under Medicare, our concerns about the administration's fiscal year 1987 budget, and our comments on S. 2368.

As requested, I shall focus on these areas; but I shall, in closing, take this opportunity to bring to your attention once again an injustice that is being done to a significant number of older Americans through the historic discriminatory limitations that are placed on psychiatric services under Medicare.

The APA has significant concerns over the President's proposals concerning physician reimbursement. The changes in the Medicare economic index proposed by the administration would only exacerbate the negative effects of the existing MEI.

Since 1976 the MEI has failed to keep pace with inflation and also with the medical care component of the Consumer Price Index. Modifying the MEI will make the index even more inaccurate as a measure of the medical care component of the CPI.

We object also to the retrospective application of the proposal, since it will result in a negligible increase in the prevailing charge level and is little more than a backdoor effort to continue the fee freeze. The retroactive adjustment will discourage psychiatrists from involvement in the Medicare Participating Physician Program and will lead toward a two-tier system of health care for the elderly.

Finally, to single out physicians for a retrospective application to this adjustment is unique. For all other groups—retirees, pensioners, et cetera—the adjustment was prospective.

We also oppose the administration's proposal concerning reasonable charge limitations. We were distressed by both the content and the process of issuance of this regulation. According to the regulation, individual carriers or groups of carriers could make determinations as to inherent reasonableness without publishing a notice in the Federal Register. Such action, we feel, is contrary to our deliberative process of government. Also, we doubt that the Government can set a fixed national value on the time a psychiatrist spends with his or her patients.

Each patient requires direct personal treatment, continual evaluation, and variable therapeutic intensity. Psychiatry is already the most undervalued medical specialty in Medicare's reimbursement scheme. Additional charge limitations will only make it increasingly difficult for beneficiaries to receive needed and cost-effective medical care.

The establishment of a Physicians Payment Review Commission, which we applaud, and the studies of physician reimbursements including the major Harvard/AMA/HCFA-funded study suggest that it would be prudent and less disruptive for beneficiaries to wait for study results before abandoning the system which has been in place for nearly two decades. The validity of CPR may be in question, but there is no compelling justification for hasty implementation of this proposed regulation. We have urged the Secretary to withdraw it and support the legislative efforts of your committee, Mr. Durenberger.

We are appreciative of the efforts that have gone into your bill, sir. While we are pleased with many aspects of the bill, particularly those areas which addressed underpriced or technologically neutral services, we are concerned that there are not enough protections in place for beneficiaries or for physicians in underserved areas.

Also, we feel the value of time which psychiatrists spend in direct treatment of their patients can be more adequately measured by a resource cost-based relative value scale, rather than by proposals such as vouchers.

We favor many of the procedural concerns addressed in the bill, including the requirement of a 60-day review of regulations, and the proposal that the Physician Payment Review Commission comment on physician payment regulations promulgated by the Secretary of HHS. We would urge that the Secretary be required to respond to these reports in writing.

We also urge that studies to evaluate new payment methods protect beneficiaries' access to health care costs, and this can best be done by conducting demonstrations of any new payment method in statistically comparable communities across the United States.

Finally, my plea, Mr. Chairman, if I may have a moment. There are millions of older Americans who are silent and who are stigmatized, and often have no one else to plead for them. One out of every five of our Nation's elderly has a significant mental illness. Over a quarter of those elderly Americans labeled "senile" actually have reversible, treatable conditions, and older Americans receive one-half of all the prescribed barbiturates; so their need is real, and it is great.

Yet, from the very inception, Medicare has singularly discriminated against them. They alone, among the elderly ill, are subject to limitations that you know well, sir: $250 a year in outpatient care, and that has not even been indexed for inflation since it was introduced over 21 years ago.

Your bill is commendable in emphasizing undervalued service, but it is silent on ways to eliminate this most blatant undervaluation of a whole group of our elderly citizens.

I thank you, sir, for the indulgence of those last comments.

Senator DURENBERGER. And I thank you for the comments.

Again, for each of you, I have a series of questions that deal not just with your testimony but with your medical specialty. I will submit those in writing, and I will appreciate your response.

[The prepared statement of Dr. McGrath follows:]

American Psychiatric Association
1400 K Street, N.W., Washington, D.C. 20005 • Telephone: (202) 682-6000

STATEMENT

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

ON

PROPOSALS TO MODIFY
MEDICARE'S PHYSICIAN PAYMENT SYSTEM

PRESENTED BY

JOHN MCGRATH, M.D.

BEFORE THE

SUBCOMMITTEE ON HEALTH
SENATE FINANCE COMMITTEE

APRIL 25, 1986

Mr. Chairman, Members of the Subcommittee, I am John McGrath, M.D., a physician in the private practice of psychiatry in Washington, D.C., and a member of the Board of Trustees of the American Psychiatric Association, a medical specialty society representing over 32,000 psychiatrists nationwide.

The APA is pleased to have this opportunity to provide you with our views about physician payment under Medicare; our concerns about the Administration's Fiscal Year 1987 budget, particularly efforts to change physician payment under Medicare through regulation; and our comments on the "Medicare Physician Payment Reform Act of 1986." Since your bill was introduced so recently, we have not thoroughly reviewed its' provisions, but would be pleased to provide more detailed comments for the record.

As requested, we focus our testimony on these areas, but we would be remiss if we did not discuss the discriminatory "caps" imposed on psychiatric treatment under Medicare.

The APA shares Congressional concern with the increasing costs of physician payment and recognizes that some adjustments may be needed in the system. However, we strongly believe that any changes made in the physician payment area should be made slowly; changes should not disrupt the quality of care and access to care, (access to psychiatric care has been limited by coverage policy), provided to beneficiaries since the inception of the Medicare program. The APA is more than willing to work with the Congress and the Administration to examine new methods of paying physicians, and to develop -- if we can eliminate Medicare's discrimination in the treatment of mental illness -- an incremental approach to providing appropriate coverage for psychiatric services under Medicare. The Association's committment to responding to such Congressional concerns is evidenced in our Council of Economic Affairs, which is currently in the process of establishing a Task

Force on Psychiatrist reimbursement to address some of the issues facing the Medicare program and other third party payors today.

REIMBURSEMENT FOR PSYCHIATRIC SERVICES UNDER MEDICARE

We recognize that the health care problems of the elderly are often more complex than those of other segments of our population. The elderly population is growing and will represent a larger proportion of the population, approximately one in five persons in the next thirty years. Many elderly people have more than one health problem and may need more than one type of health care provider. Estimates indicate that some 15 to 20 percent — between 3 and 5 million -- of our nation's more than 25 million older persons have significant mental health problems, yet they are denied adequate treatment because of the discriminatory "caps" imposed on psychiatric treatment under Medicare. Under the current Medicare system, outpatient benefits are restricted to $250 per year after coinsurance and deductibles, and this amount has not been increased since the Medicare program's inception in 1965. Thus, if a patient had met the deductible and could afford $250 in coinsurance, they would be eligible for approximately 5 visits to their doctor in one year. Statistical estimates also indicate that twenty to thirty percent of older Americans who have been labeled "senile" actually have reversible, treatable conditions. If adequate mental health coverage were provided, these beneficiaries could become productive, active members of society, and avoid unnecessary and costly hospitalization. Coverage of the mental health needs of these elderly people under Medicare could provide the mentally ill elderly the dignity, productivity, and independent living which are the keystones of the Older Americans Act of 1965.

Clearly there are instances where the compelling limitation on outpatient psychiatric care forces use of more expensive inpatient care, and adds avoidable expenditures to an already strapped Medicare program. In fact, the offset effect -- a reduction in health care utilization when mental health services are provided -- has been documented in many studies. For example, researchers have demonstrated decreases in inpatient utilization when outpatient mental health benefits are offered. A meta-analysis of 58 controlled studies, and an analysis of the Blue Cross and Blue Shield Federal Employees Plan claims for 1974-1978 found the cost-offset effects of outpatient mental health treatment resulted primarily from reductions in inpatient utilization. The offset effect was greater for individuals aged 55 and over (Mumford, Schlesinger, Glass, Patrick, Cuerdon, 1984).

One recent NIMH study of Aetna Life Insurance Company's claims for enrollees in the Federal Employee Health Benefits Program compared the overall health care service use by families which did and did not use mental health services from 1980 to 1983. Prior to the initiation of mental health treatment, use of overall health services rose gradually for three years with a sharp increase during the six months immediately preceding mental health treatment. Once mental health treatment was initiated, overall health use fell, and the greatest decrease in health utlization occurred for persons over age 65. Overall, general health use cost $493 per month for the six months just prior to initiating mental health treatment and $137 per month three years after treatment. The additional cost of mental health treatment was $13.96 per individual covered by the plan. The authors of the Aetna study caution that interpretation of other data over short periods of time may mask the dramatic nature of changes in health care service utilization after mental health treatment commences. (Holderand Blose, 1985). Other studies have also demonstrated a decrease in hospital treatment after use of mental health services (Mumford, Schlesinger and Glass, 1983); and one review of the literature found a 20 percent reduction in health care costs associated with mental health treatment (Jones and Vischi 1979). These results suggest that the Medicare population has been denied the mental health treatments it needed, and potential significant cost saving have been lost.

The costs and benefits of liaison psychiatry have also been documented in the literature. All the components of these services -- for instance, discussions with family and staff -- are not fully reimbursed under Medicare. A controlled study examined clinical outcomes of a group of elderly patients (age 65 and over) who underwent orthopedic surgery for fractured femurs. Those receiving liaison psychiatric services stayed in the hospital 12 days less than patients who did not receive such services. (A several thousand dollar cost saving by any measuring device). The treatment group was also twice as likely to be discharged home instead of to a nursing home or other health-related institution. Thus, liaison psychiatry services provided clear cost savings by reducing health care utilization in other portions of the health sector.

We all know elderly people, and we watch as they lose close friends, relatives, and meaningful work. These assaults on their self-esteem are likely to put people at significant emotional risk. For instance, in 1982, the population over age 65 accounted for just over 10% of the U.S. population, but 17% of deaths by suicide. Also estimates indicate that people over age 65 receive as much as half of the prescribed barbituates and sedatives.

The psychiatrist is uniquely trained to treat the patient who requires both pharmacotherapy and psychotherapy, an increasingly frequent therapeutic prescription in an era of advancing understanding of complex biopsychosocial components of mental illness. This is an especially important point on which I would like to elaborate. Within the past few years, exciting new breakthroughs in the treatment of mental disorders have significantly changed not only our understanding of the causes of mental disorders; but have also given us the ability to treat such disorders more effectively. For example, through recent research we have attained the capacity to effectively treat more than 85% of all severe depressions using drugs and psychotherapies; we have verified the existence of a genetic component to the psychoses, and determined that environmental events may trigger one's inherited risk or predisposition for a given disorder; we have refined techniques for diagnosing mental illness, which permits treatments to be tailored specifically to a patient's needs and ensures comparability of results in clinical research; we have gained a capacity, through techniques such as positron emission tomography and nuclear magnetic resonance, to observe biochemical activity in the conscious brain and define discrete areas of the brain that may be defective in certain illnesses. Finally we have developed pharmacologic and behavioral treatments that are effective in treating phobias and other anxiety disorders, demonstrated that memory loss and other cognitive deficits associated with Alzheimer's Disease may be modifiable with medication, and improved methods for assessing the effectiveness of psychotherapy and for identifying specific types of psychotherapies best suited to specific disorders. An impressive, but not even an exhaustive list. Medicare coverage policy prevents the elderly from receiving the benefits of these breakthroughs.

Additionally, psychiatric symptoms are frequently non-specific and commonly occur in medical, as well as psychiatric disease. There is evidence indicating that having a psychiatric diagnosis is associated with a high risk of medical illness. Also, there are a great many physical illnesses that, upon initial presentation, appear to be nervous and mental disorders.

The research literature fully documents psychiatric illness produced by infections, thyroid gland dysfunction, chronic encephalopathy related to heart block, carcinoma of the pancreas, hyper-parathyroidism, Wilson's disease, sub-acute encephalitis, and strokes.

These studies also emphasize the importance of the interrelationship between specific psychiatric symptons and specific medical diseases. Physicians in practice must continually weigh such psychological factors as personality traits to properly treat rheumatoid arthritis, hypertension, peptic ulcer, diabetes, ulcerative colitis, allergic skin infection, bronchial asthma, coronary disease and cancer.

Despite these many mental health needs, the elderly population receives only 6 percent of community mental health services and 2 percent of private psychiatric services (Mumford and Schlesinger 1985). Medicare mental health coverage policy has discouraged our Medicare patients from seeking psychiatric care. Most researchers agree that the mental health needs of the Medicare population are underserved, and disagree only on the extent of underservice. The recent Harvard Medicare report recommends that coverage of mental health services be expanded.

ADMINISTRATION'S FISCAL YEAR 1987 BUDGET PROPOSALS

The APA has significant concerns over the President's proposals concerning physician reimbursement. First, changes to the Medicare Economic Index (MEI) proposed by the Administration would only exacerbate the negative effects of the existing MEI. Based on available data, between 43 and 60 percent of approved charges for physicians services in 1983 and 1984 respectively, were found to be at the adjusted prevailing charge ceiling. The MEI has failed to keep pace with inflation since 1978 and has failed to keep pace with the medical care component of the consumer price index. Modifying the MEI by recalculating housing costs, in particular taking into account rental costs, would be consistent with recent modifications to the CPI, but would continue to make the index an inaccurate measure of the health care industry's medical care component of the CPI. Psychiatric patients, who have been discriminated against under Medicare, would be particularly affected by additional limits to payment.

The APA strongly objects to the content of the proposed readjustments, and to the retroactive application of the proposal. This retroactive application of the Index will result in a negligible increase to the prevailing charge levels, and is only a back door approach to continuing the fee freeze. Despite the effective lifting under COBRA of the fee freeze for some physicians on May 1, 1986, psychiatrists would again be subjected to a fee freeze by the retroactive application of the MEI changes. APA is concerned that the retroactive adjustment will discourage psychiatrists from involvement in the Medicare participating physician program, and will lead to a two-tier system of health care for the elderly. Even now Medicare policy provides only minimal psychiatric care and so already encourages a two-tier system.

Next, the APA is opposed to the Administration's proposal concerning Reasonable Charge Limitations, published in the Federal Register February 18, 1986 (BERC-349-P). We were distressed by both the content and the process of issuance of this regulation. While a 15 day extension was granted to the published 30 day comment period, the change was not made in a timely fashion. Therefore, many interested parties did not have the time needed to adequately respond to this major revision of Medicare physician payments.

HCFA further undermines the public comment process through the content of the regulation. According to the regulation, individual carriers or groups of carriers may make determinations as to "inherent reasonableness", without publishing a notice in the Federal Register. Thus, HCFA would attempt to bypass the Federal Register and implement charge limits through the carriers. These actions are contrary to the very core of our deliberative process of government.

In addition to our concerns about the comment process, the APA questions the statutory authority of the Health Care Financing Adminstration (HCFA) to make this radical change in physician reimbursement by regulation. The preamble to the proposed regulation partially quotes from the Social Security Amendments of 1972 (P.L. 92-603) as the authority for proceeding by regulation " . . . present law provides for special reasonable charge rules and limits with respect to any item or service for which such special rules are found to be necessary and appropriate." However, if one reads the entire paragraph from which this phrase is excerpted, the Committee makes clear that it was referring not to wholesale price-fixing by HCFA, but to the possible limitation on charges for "routine follow-up visits to institutionalized patients" or for visits on the same day to multiple patients within an institution. Therefore, HCFA's authority to proceed by regulation is unsubstantiated, and its reliance on random phrases misleading.

The preamble to the regulation states that HCFA is primarily concerned with "those cases in which payment may be excessive. We believe that situations in which the reasonable charge mechanism results in a significantly deficient amount are virtually nonexistent." The APA disagrees with this statement. Indeed, this proposal appears to be geared toward hardware and technology, and leaves no room for physicians' thought, diagnostic research skills, and most importantly, time spent with a patient. Adjustment must also be made to reimbursement for those under-compensated services.

The APA also questions how the government can set a fixed, national value for the time a psychiatrist spends with his or her patients. Each patient requires direct and personal treatment, continual evaluation and variable therapeutic itensity. In fact, the undervalued payment for psychiatric services is made even more inequitable and arbitrary by the limit on Medicare reimbursement for outpatient psychiatric care ($250 per year after coinsurance and deductibles). Psychiatry is the most undervalued and poorly reimbursed medical specialty. The spectre of further charge limits will make it increasingly difficult for psychiatrists to treat program beneficiaries, and therefore for the population to receive needed and cost-effective medical care.

The proposed regulation also states that prevailing charges in other areas will be considered in determining whether a charge is inherently reasonable. This is truly unrealistic and will result in a system that is uniform only in its lack of fairness. Psychiatrists providing care in one area obviously have different practice costs than those in another area, these costs are also likely to be different for urban and rural areas. The APA would venture to guess that even the General Services Adminstration pays different rents for HCFA regional offices in different cities. In addition, there are other costs, such as liability insurance rates, which vary from state to state. National charge limits would severely affect psychiatrists and all physicians in more costly areas of the country.

Both the establishment of a Physician Payment Review Commission under COBRA and the many studies being undertaken regarding physician reimbursement, (including a major effort funded by HCFA to be conducted by Harvard University with a subcontract to the American Medical Association), suggest a need to proceed with changes to physician payment in a slow and deliberate manner. It would be prudent and less disruptive for beneficiaries, for HCFA to await the studies and indication of the Physician Payment Review Commission before abandoning a system which has been in place for nearly two decades. While the validity of the CPR concept may be in question, there is no statutory justification for hastily implementing the proposed regulation. APA has urged the Secretary of HHS to withdraw the proposal and supports the legislative efforts of the Finance Committee in this direction. In addition, we urge a 60 day comment period for all proposed rules, especially rules seeking to totally revamp the way in which Medicare pays physicians.

MEDICARE PHYSICIAN PAYMENT REFORM ACT OF 1986

At the outset, we wish to express our appreciation of all the work and effort that has gone into the creation of the "Medicare Physician Payment Reform Act", so recently introduced. Because of time-frame allowed for review, our comments focus on aspects of the bill which may need further clarification. Some of our thoughts on its contents are less detailed than those we might otherwise have provided. Therefore, Mr. Chairman, if you would like, we would be happy to provide you with additional comments for the record.

Overall, we were pleased with many aspects of the bill, specifically those areas which addressed "underpriced" or technologically neutral services. In some cases, we were concerned that there were not enough protections in place for beneficiaries, or for physicians from underserved areas. For example, the value of time which psychiatrists spend in direct treatment of their patients may be more adequately measured by a resource cost based relative value scale than by other proposals such as vouchers. The bill also addressed some procedural concerns including the requirement to allow 60 days for review of regulations, and the proposal that the Physician Payment Review Commission (PPRC) comment on physician payment regulations promulgated by the Secretary of Health and Human Services. We comment on the bill section by section below.

Procedures for Establishment of Special Limits on Reasonable Charges:

Factors Taken Into Account in Determining Reasonable Charges. Are the factors presented in this section meant to be mutually exclusive? A strict interpretation of some factors might lead carriers or other authorities to inadvertently lower payment in certain areas. Let us take the example of a psychiatrist from a rural area who has a slightly lower charge relative to other psychiatrists in rural areas. If the psychiatrist, in turn, is the only person practicing in his/her area, and rules were applied in a stringent fashion, it is possible that fees might be lowered because of no competition from others (despite the sole provider provisions). The psychiatrist might seek other markets of care, thus further inhibiting beneficiary access to care. If the factors are meant to be used concurrently, these sections indicate the potential need for an algorithm which weights the different factors.

The APA would prefer a more careful definition of "other comparable localities" as mentioned in Section (B)(i)(I). Such a definition might state that communities must be statistically comparable on all demographic factors, with particular attention to the distribution of generalist and specialist physicians per 100,000 population.

APA appreciates the government's attempt in Section (B)(i)(II) to be a "prudent buyer", when purchasing the major portion of a service in an area. We assume this section refers to high technology services, however, we are concerned that this section could be inadvertly misinterpreted at a later date. One must be careful that beneficiaries are not accidentally denied access to care. For instance, in many rural areas there are a few psychiatrists. If the area also has a\high proportion of elderly people, the government might conceivably be the sole purchaser of the service. In these instances, does the system really want to require lower prices?

Again, in Section (B)(i)(III) APA understands Congress' intent to encourage the government's prudent purchases of care, but in certain areas they may only be a few providers who can offer a service. For instance, 1980 data shows that the psychiatrist to population ratio was of 12.8 psychiatrists per 100,000 people for the nation as a whole. The state of Idaho had 2.7 psychiatrists per 100,000 people, Montana had 2.7 psychiatrists per 100,000 people, and Wyoming had 2.5. In some of these states the marketplace may not, in fact, be competitive, but if Medicare prices were lowered for some of these physicians in underserved states, access problems may occur for some elderly beneficiaries. The definition of the marketplace may need to vary in different parts of the country. In some parts of the country, beneficiaries may actually be competing to see a psychiatrist for a services.

APA requests that in Section (B)(i)(IV) physicians have input into determining factors which could be included in the index.

As we have mentioned before, although we understand the desire of Congress in Section (B)(i)(VI) to have our government purchase services prudently, we are concerned about who will make the decision about the right price? We would suggest that physicians should be involved in this process.

APA agrees with the concept of regional differences in fees as mentioned in Section (ii), because the costs of practice, the costs of living etc. are different across all areas. But the term "substantial economic justification" for moving to a national rate needs further definition or must be discussed more fully in report language. Physician input is needed to determine a change that eradicates the Medicare concept of different fees for each physicians' service. Some psychiatrists in certain areas of the country may be changing their style of practice and this may affect what is included in their practice costs and the composition of their charges.

APA applauds your attempt in Section (9)(a)(i)(ii) to include not only "grossly excessive" but "grossly deficient" charges under the concept of inherent reasonableness. Again, we feel it important that physicians be involved in these determinations. Psychiatry, for instance, has concerns not only about the unit price for care, but about the availability of outpatient services for elderly patients. In situations where a psychiatrist could either treat a patient on an outpatient or inpatient basis, a physician may need to hospitalize a patient for clearly medically necessary treatment, because so little coverage is provided the beneficiary for his or her outpatient care.

The Secretary, in Sections (9)(B)(C)(D)(E), should not only publish the method of charge determination, but also seek counsel from physicians in the initial development of the method. We agree with the concept of enpowering the Physician Payment Review Commission (PPRC) with review of proposed regulations, but we would urge an amendment. A further section would provide that although the Secretary would make his own decisions, the Secretary would be developed, would be required to provide written comment on reports and responses to regulatory initiatives issued by the PPRC.

Development of a Fee Schedule for Physicians' Services

In principle, APA supports the investigation of a resource-cost based relative value scale for the purposes of conversion to a payment schedule in the future. The studies funded by HCFA at Harvard with an AMA subcontract should be a step in this direction.

An index of practice costs should allow for flexibility in the future, because components of practice costs change overtime. In Psychiatry, extensive medical history is becoming more important as additional physicians become involved in coordinating patient histories and monitoring the pharmacologic agents which elderly people must take. This may not be as much of an issue now as it will be in the future. Therefore, physicians must be involved in setting up such an index, and the system must be one that has potential for change as practice styles change.

This section also implies that an RVS might be based on historical charges. Such a system is likely to build in the inherent inequities in the current system, in particular for psychiatry -- long undervalued in reimbursement scheme.

We concur with your statement that a payment system should not exacerbate problems with the geographic distribution of physicians.

As the Secretary of HHS develops an interim index, we hope that he will consult with physician groups. Only physicians currently in practice can suggest areas which ought to be included in the index, because of changing practice patterns. Some areas which may need to be incorporated are the cost of continuing medical education, drugs and medical supplies, and depreciation on medical equipment.

We would support the idea of a study to look at the advisability of redefining pay localities as designated by the carriers. We would hope that the PPRC would also comment on this process, and we hope the study will address the problems which may occur if charge areas are reduced too far.

Development and Use of HCFA Common Procedure Coding System—Section 4

In some instances, codes may be written in such a fashion that services are understated for billing purposes — for example, liaison psychiatry. The section implies a reduction in the number codes for payment purposes. It is APA's feeling that a report should be issued on this area by July 1, 1987, rather than an actual change to the system.

The initial brainstorming regarding the adoption of the HCPCS system included physicians. Physicians should also be represented in any proposals to change the system.

Hospitals already using CPT-4 for outpatient billing will not find difficultly in converting to HCPCS (which is based on CPT-4). For those hospitals currently using another system, coversion may be more difficult.

Section 5. Medicare Economic Index for Physicians

Although APA is opposed to retroactive adjustments to the MEI, we appreciate the Senate Finance Health Subcommittee's efforts to lengthen the time of implementation. We are still concerned, however, that this change may affect certain of the "undervalued" services more heavily.

ADDITIONAL RECOMMENDAITONS

APA supports Congressional efforts to implement change in physician reimbursement under Medicare, but such change must be implemented only after careful study of all alternatives and must include expansion of coverage for mental health services provided by psychiatrists. Studies to evaluate new payment methods must protect beneficiaries' access to quality health care. This protection can best be afforded by conducting demonstrations of new payment methods in statistically comparable communities across the United States. APA supports equitable reimbursement for both procedural and nonprocedural (cognitive) services. In this light, we are in favor of the exploration of resource-cost based relative value scales through the HCFA funded studies. After appropriate investigation, these RVS, if found adequate, might then be used with regional monetary conversion factors to pay physicians under Medicare. We would be concerned about implementing a relative value scale and subsequent conversion factors based on historical charges. Such a method would only freeze into the payment methodology many of the inequities for psychiatrists present in the current system. APA remains opposed to the concept of mandatory assignment, because it interferes with the physician/patient relationship.

Although we recognize that these are times of fiscal constraint, we would be remiss if we did not point out again our concern that the Medicare program does not address the critical needs of the elderly for treatment of mental illness. With current reimbursement practices, the elderly are covered for $250 after their $75 deductible and 50 percent coinsurance. APA is willing to work with Congressional committees and the Administration to explore a Medicare program coverage expansion that would take place only with a stringent peer review process in place. Psychiatric peer review, as implemented by APA for other federal programs -- and in the private sector -- has demonstrated its success in maintaining quality care to beneficiaries, while at the same time, saving scarce government resources and protecting patient medical record confidentiality.

CONCLUSION

In conclusion APA understands the need for physician payment reform under Medicare. We join our colleagues in expressing concerns about the inequities in payment for certain services and the proposed changes to the MEI. In addition, we were quite distressed with both the content and process of issuance of the regulation issued by the Administration regarding "inherent reasonableness." Because of the historic discrimination against psychiatric services under Medicare, we recommend changes in coverage for mental health services. While we urge the immediate abolition of Medicare's historic discriminatory coverage for the treatment of mental illness, we would understand a step-wise approach to improved psychiatric coverage. We recommend these changes only with the implementation of strong, psychiatric peer review. Finally, and as a major recommendation to the Committee, we feel it is important that a psychiatrist be appointed to the PPRC. This need is dictated by the special problems of reimbursement for psychiatric services, and by the very special, unmet mental health needs of Medicare beneficiaries. This person should be strongly, based in organized Medicare so that he/she could simultaneously serve the needs of all beneficiaries. We recommend payment changes only after careful demonstrations in communities with statistically comparable populations.

As we have pointed out throughout our comments, we request that physicians be involved in working on any changes to reimbursement. Although you emphasize undervalued services in the "Medicare Physician Payment Reform Act of 1986" as well as overvalued services, your bill does not suggest any ways to eliminate the discrimination that currently exists for psychiatric services.

Senator **Durenberger**. On the last point Dr. McGrath, I don't know whether $250 was adequate in 1965 when we put it in place. Today it is ridiculous. In fact, it probably is bad for our health just to have it there. And yet it is emulated in the private insurance sector as well—I mean, that basic philosophy is emulated all over, whether it is psychiatric, or chemical dependency treatment, or any of these things where you can't see blood on the carpet, so to speak. There is definitely a hospitalization bias.

I wonder if you have a recommendation for us on what a benefit would look like which would meet the mental health needs of the elderly and disabled while discouraging overutilization of services?

Dr. **McGrath**. Yes, I do, sir.

The goal, of course, would be health care for the mentally ill elderly that is equal to that provided for the physically ill elderly. Now, incremental steps to that goal might include—and here I would stress that the important thing is not the absolute number of visits or the day in hospital, but that there be authorization for medically necessary treatment on a case-by-case basis.

Peer review for psychiatry is an ongoing realty. We have a contract with the Department of Defense that is many years old, and we contract for peer review with 40 major insurance carriers, and I can supply you with figures—not off the top of my head sir—for both of those.

The Department of Defense claims that these peer review programs have saved them millions of dollars annually. The Champus benefit package might serve as a template, as a first step. It is a benefit package that, because it has peer review, can address medical necessity, so that when we have significantly mentally ill people, they can get only the treatment they need, and the utilization and cost of that treatment is constantly under scrutiny.

The best of the FEHBP packages for the Federal workers, those too have benefits that might serve as a template.

I heartily hasten to add, sir, that we would work with you in any way in moving toward the goal in incremental steps, because we too feel that it is a ridiculous coverage to offer to our needy elderly citizens.

Senator **Durenberger**. Well, let me just say there is no time like the present. And let me say to you and to others, who I have described by example, that now is the time to come up with some recommendations; between now and the time we start putting into effect a new system for reimbursement is the ideal time to work in mental health and some of these other services.

But it seems to me that the onus—and I don't mean that in a negative sense, but the burden—is largely on you and your colleagues. You know where this system is going, you know how it pays off, so to speak. So the burden is largely on you to make the recommendations to us.

One of the burdens that I think we carry is to be cognizant of the fact that in competition and consumer choice the prepaid health plans tend to discriminate against your kinds of services.

I take you back to my example all of the time in the Twin Cities, where it is quite evident that the HMO's and some of the other prepaid plans are not taking advantage of some of the good mental-health and chemical-dependency services that are available in that community, largely because of some concern that I suppose they have about costs and outcomes, and so forth. So, we know their proclivity. You have the answer somewhere to the problem, and maybe we ought to find some way in the next year to 18 months to come together for some solutions.

Dr. **McGrath**. I certainly hope so, sir. We accept that onus, and don't view it as an onus at all. We are very grateful.

Senator **Durenberger**. Thank you all very much. We appreciate your testimony.

The final three experts, I would like to call up at the same time: Larry Morris, senior vice president, Health Benefits Management for Blue Cross and Blue Shield; Carol Lockhart, senior research fellow, Boston University, on behalf of the American Nurses Association; and Ron Nelson, chairman, Legislative and Government Affairs Committee, American Academy of Physician Assistants, from White Cloud, MI.

Gentlemen and women, we have your statements. They will all be made part of the written record. I also have a series of questions to address to each of you which we will propound in writing, and we look forward, with our various audiences here today, to your summarizing that testimony.

We will begin with Larry Morris. I appreciate your being here again, Larry.

STATEMENT OF LAWRENCE C. MORRIS, SENIOR VICE PRESIDENT, HEALTH BENEFITS MANAGEMENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, CHICAGO, IL

Mr. **Morris**. Thank you, Mr. Chairman, it is a pleasure.

We appreciate this opportunity to comment on the many things that have happened since our last appearance before this committee. In that time, the administration, the Congressional Budget Office, and the Office of Technology Assessment have recommended various proposals and options, and most recently you and Senators Dole and Bentsen have submitted physician reform legislation.

Our written testimony, which you have for the record, comments in some detail on these proposals, and I would like to summarize those comments, if I may.

Mr. Tresnowski stated in our December testimony that we feel it is time to move ahead with physician payment reform, and in the testimony today we reaffirm a basic four-point strategy for accomplishment that end.

First, we believe that the Federal Government's long-term objectives should be to expand significantly beneficiary enrollment in private benefit plans. Therfore, we support the Congress' and the administration's efforts to increase the number of beneficiaries joining HMO's and CMP's.

In addition, we think it is important to move ahead with demonstrations of the Medicare voucher and geographic carrier concepts.

Second, we support revising the current CPR payment system, and moving toward fee schedules that recognize appropriate variations. We believe that fee schedules can be developed from historic charge and payment data and adjusted to reflect additional information.

The Physician Payment Review Commission established by Congress should be very helpful in that process.

Third, we suggest that part B medical-review and utilization-review activities be strengthened. Fee schedules are not going to eliminate the need to manage increasing service volume, and steps can be taken to improve the program in that area.

Fourth, we recommend that Medicare support an all-or-none assignment policy, requiring each physician to choose whether to accept assignment on all claims or accept assignment on no claims. The advantages of participation should be reinforced and publicized, both to physicians and to beneficiaries.

Our comments on the administration's 1987 budget proposals, the options put forth in the proposed Medicare Reform Act, and the recent Congressional Budget Office and the Office of Technology Assessment reports all flow from the position that I have just outlined.

Generally, we support initiatives to create a more accurate Medicare economic index and make selective adjustments in certain physician payment screens. We are concerned, though, that these changes be implemented fairly and be consistent with the objectives of the Medicare Program.

For example, the administration's proposal to make retroactive reductions in the MEI does not seem to us to be consistent with efforts to reward participating physicians and to increase assignment and participation levels.

We also comment at some length on the Medicare physician payment reform legislation submitted by yourself, Mr. Chairman, and Senators Dole and Bentsen. In general, we support that legislation. The bill includes some very positive proposals regarding the physician payment program. We do have some serious concerns with a few points in that bill, and we will suggest some changes.

In the process of mentioning those, I want it not to be overlooked that there is some very good thought in that bill.

In the context of both the proposed national reasonable charge limitations and the development of an index to adjust allowances for geographic differences, we recommend considering sensitivity to local market factors as well as resource cost and other information. Such factors are important to assure adequate levels of participation and assignment, and in order to protect the beneficiary from added out-of-pocket expenses.

We have some concerns about the proposal to apply the HCPCS coding system to billing and paying for all hospital outpatient services. This may or it may not be a good idea. It raises significant policy and significant technical problems which we simply haven't had time to work our way through in the time that we have had the bill. We urge the committee to consider such a major change in the context of an overall legislative strategy to pay for outpatient services and not as isolated activity.

Finally, regarding the bill's MEI proposals, we recognize that there are differences of opinion over whether and how to recapture the MEI's past overstatement of office rental costs. Our recommendation is simply that the committee not permit payment levels for participating physicians to deteriorate, because that would have the effect of undermining the integrity of Medicare's participation program and reducing financial protection for some beneficiaries.

Regarding the CBO options on fee schedules, we reiterate our support for the fee schedule concept for Medicare. We do not believe, though, that the CBO's suggestions to adjust fee schedules to reflect service volume changes are workable on an open panel—and I stress "open panel"—basis. These changes would likely result in distoring physician practices and increasing out-of-pocket expenses for beneficiaries.

The OTA report gives a thoughful analysis and a very useful framework for considering ways to improve Medicare's physician payment system. We support many of the options and have identified them in our testimony.

Again, Mr. Chairman, we thank you for this opportunity, and if you have questions I will be glad to try to answer them.

Senator **Durenberger**. Very good. I appreciate that very much. Carol?

[The prepared statement of Mr. Morris follows:]

TESTIMONY

OF

THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

PROPOSALS TO MODIFY MEDICARE'S PHYSICIAN PAYMENT SYSTEM

BEFORE

THE SENATE FINANCE SUBCOMMITTEE ON HEALTH

LAWRENCE C. MORRIS

SENIOR VICE PRESIDENT

APRIL 25, 1986

Mr. Chairman and Members of the Subcommittee, I am Lawrence C. Morris, Senior Vice President, Health Benefits Management, of the Blue Cross and Blue Shield Association, the national coordinating organization for all the Blue Cross and Blue Shield Plans. These Plans have been managing health care benefits and designing and administering various payment arrangements with physicians, hospitals and other providers of health care for over 50 years. Today in the private health insurance market Blue Cross and Blue Shield Plans underwrite and administer health care benefit plans for 78 million subscribers. Under contracts with the Health Care Financing Administration, Plans serve as Medicare fiscal intermediaries and carriers, responsible for most of the day-to-day administration of this important program.

We appreciate the opportunity to contribute to your review and consideration of various proposals to improve Medicare's physician payment system. The Administration, the Congressional Budget Office and the Office of Technology Assessment have all recently made proposals or presented options to modify the way in which Medicare pays for physician services. In addition, Senators Durenberger, (MN), Dole (KS), and Bentsen (TX), have recently developed a proposal on this subject. I will comment on these proposals; but before doing so, I would like to review the Association's position on Medicare physician payment reform.

BLUE CROSS AND BLUE SHIELD ASSOCIATION POSITION

First of all, we believe that the federal government's long term objective should be to expand significantly the number of beneficiaries enrolled with private organizations that agree to provide Medicare benefits in exchange for a fixed capitated payment from the government. This could include exploration of "voluntary voucher" approaches or other capitation methods. To move in this direction, we support both the Congress' and the Administration's efforts to increase the number of Medicare beneficiaries joining HMOs and CMPs. We also urge that geographic carrier capitation demonstrations be pursued without delay.

Second, we believe the government should simultaneously pursue interim measures to address the most pressing problems of the current physician payment system. This includes taking steps to correct unsupportable extremes, both high and low, in payment rates for selected procedures and across geographical areas.

In conjunction with these actions to eliminate some of distortions of the current system, the government should consider phasing in fee schedules. With the assistance of the new Physician Payment Review Commission and other groups able to offer expert advice on physician payment issues, fee schedules could be based initially on charge data, adjusted over time to reflect physician resource costs, procedure code changes, geographic variations and other factors.

Third, as we stated in our December 6, 1985 testimony before this Subcommittee, improving controls over the increasing volume of physician services, which account for about 40 percent of the recent growth in Part B expenditures, is very important. Although medical and utilization review (MR/UR) activities have received more attention lately, we believe more needs to be done. In particular, carriers should be provided greater flexibility and resources to develop and implement cost-effective MR/UR screens based on sound analysis of both their Medicare and private sector experience. We also recommend that the Congress change the PRO law to remove the arbitrary disadvantage that intermediaries, carriers, and other payer organizations face when bidding for PRO contracts. In this way, HCFA could have the option of selecting whichever organization can best achieve the results it expects from the PRO program.

Fourth, we recommend that Congress adopt an "all-or-none" assignment policy for Medicare. Under such a policy, each physician would choose periodically whether to accept assignment for all Medicare claims or no Medicare claims. Beneficiaries would continue to be reimbursed directly by Medicare for services provided by non-participating physicians. Essentially, this would mean eliminating case-by-case assignment while retaining and enlarging the physician participation program.

RECENT CONGRESSIONAL ACTION

Before moving to our comments on specific reform proposals, I would like to recognize this Subcommittee's and the Congress' recent actions affecting Part B physician payment. For example, the Physician Payment Review Commission authorized by the FY 1986 reconciliation act should assist greatly in modifying the current payment system and in developing a realistic fee schedule. We also commend the Congress' recognition in this legislation of the need for improved, more predictable funding of carrier and intermediary MR/UR activities.

In addition, the provisions of the reconciliation act that honor the government's earlier commitment to increase payment limits for participating physicians will help to strengthen the participation program. We are also pleased that this legislation authorizes steps that will help make directories of participating physicians and suppliers more meaningful and useful for beneficiaries. We note, however, that HCFA's current policy of directing carriers to increase claims backlogs and pay claims more slowly may undermine these positive steps. Such delays can only have an adverse effect on beneficiaries and could ultimately discourage physicians from participating or taking assignment.

COMMENTS ON PHYSICIAN PAYMENT PROPOSALS AND OPTIONS

Having described our general views on Medicare physician payment reform, I would now like to comment on various proposals and options described in the Administration's FY 1987 budget; the recent proposal by members of the Committee; and the recent Congressional Budget Office (CBO) and Office of Technology Assessment (OTA) reports.

Administration Proposals

The Administration's budget includes several provisions intended to make selective reforms in physician payment. Among these are:

- Adjustment of the Medicare Economic Index (MEI) to correct past overstatement of office rental costs.

- Selective reduction of physician payment screens for procedures that are overpriced due to technologic productivity, or geographic factors.

With respect to the MEI changes, we understand that HCFA plans to make a downward adjustment in the MEI to reflect office rental costs more accurately. The Bureau of Labor Statistics made a similar adjustment in the CPI for housing costs. However, the Administration also plans to apply this adjustment in a manner that would reduce this year's MEI increase dramatically to make up for the overstatement of office costs in previous years.

We support changes that result in a more accurate and technically sound MEI. In the interest of equity and where justified by the data, upward adjustments may also have to be made occasionally to correct understatements in certain cost components. But, we oppose making retroactive MEI adjustments that would unduly penalize participating physicians and increase beneficiary out-of-pocket costs on unassigned claims. CBO estimates that the Administration proposed MEI recalculation would reduce the FY 1987 increase to less than one percent. This change, together with a potential Gramm-Rudman-Hollings reduction of 2 percent would be even more stringent than freezing the fees of all physicians for yet another year. This does not seem consistent with the intent of the reconciliation act to reward those physicians who signed participating agreements with the Medicare program in the past and to encourage physicians to participate in the future.

With regard to targeted reductions for selected, overpriced procedures, we support the government's taking initiatives in this area. Our major concern is that such initiatives be designed and implemented reasonably and fairly.

The most detailed glimpse we have of how such an initiative would be undertaken is HCFA's proposed regulation published in the February 18 Federal Register. HCFA proposes to establish special national charge limitations when the standard reasonable charge calculation for selected services results in payments that are overpriced in relation to such factors as resource costs and charges for other services of comparable risk and complexity. Before promulgating a special charge limitation, HCFA would publish and request comments from the public on any proposed adjustment and the rationale behind it. In addition, Part B carriers would continue to exercise their authority to make inherent reasonableness decisions and to grant exceptions to the special national limitations. We think this process is workable and sound decisions can be made if the regulatory authority is applied carefully, selectively, and in the public arena.

The Administration proposes other steps to improve Medicare's physician payment system, such as limiting payments for standby anesthesia and assistants at surgery. While we do not have all of the specifics of these proposals, we concur that medical policy is an important element in the management of payment systems. However, there are relevant and important initiatives that appear to be missing from the Administration's program. One is the need to enhance Part B UR/MR activities, as discussed earlier, to control better the substantial and expensive increases in service volume. Another step we recommend is to move ahead, without delay, to demonstrate carrier capitation programs. And finally, the government should address the pressing need for more research on refinements and alternatives to the current method for calculating Medicare capitation rates for HMO and CMP programs. In particular, we recommend exploration and development of better means for setting and adjusting capitation rates that reflect the varying risks associated with different enrollee mix and other factors.

The Durenberger-Dole-Bentsen Proposal

The proposed "Medicare Physician Payment Reform Act of 1986", developed by Senators Durenberger, Dole and Bentsen, would make a number of important changes in the Medicare program.

It would:

- Specify procedures for establishing limits on reasonable charges, identify factors that may be taken into account in establishing such limits, and require the Secretary to take into account regional differences in fees unless he can provide substantial economic justification for not doing so;

- Require the Secretary of Health and Human Services to develop an index to adjust for geographic differences in physician practice costs and to achieve a more appropriate distribution of physician supply;
- Require the Secretary to study the advisability of redefining the multiple localities used by some carriers to calculate charge screens under the current payment methodology;
- Require HHS to simplify payment procedures under the HCFA Common Procedure Coding System (HCPCS) to minimize improper billing of service intensity,
- Require hospitals, Medicare carriers, and fiscal intermediaries to adopt HCPCS for purposes of billing and paying for hospital outpatient services; and
- Phase in adjustments in the Medicare Economic Index (MEI) to account for earlier overstatement of office rental costs.

Overall, these are sound and thoughtful proposals. They address a number of difficult problems. While we want to comment on them as specifically as we can, we do so with the understanding that the proposal is new and some of the provisions require more study than we have been able to give them in a short time.

With regard to the first proposal, the bill's language would provide HCFA with the necessary legislative authority and guidance to proceed with its proposed regulation to establish special charge limitations for selected services that are not properly priced in relation to actual resource costs or other factors. In fact, this bill, together with the language in Section 9304(a) of the recent reconciliation act, appears to give HCFA the guidance needed to develop effective regulation in this area.

Importantly, this proposal makes clear that special national charge adjustments should apply to procedures where current charge limits are too low, as well as to those where limits are too high. It lists specific factors that should be considered in developing special adjustments. Several of these factors define more precisely the concepts underlying HCFA's proposed regulation, such as whether Medicare and Medicaid are the sole or primary sources of payment for a service and whether charge levels can be justified in relation to changing technology. We support this approach. We would also suggest adding other considerations to the list of factors such as the level of participation and claims assignment achieved for a procedure under the normal CPR payment methodology.

The proposal also specifies minimum requirements for public disclosure and public comment to guarantee the openness of this regulatory process. We believe these requirements are an important assurance that this authority would not be used arbitrarily and solely for the purpose of reducing budget deficits.

We do, however, have some specific concerns with this special charge limitation process as it is described in the bill. First, we hope this proposal does not restrict current Part B carriers' authority to make inherent reasonableness decisions. Also, we would ask the committee to assure that carriers be able to grant exceptions to special charge limitations where necessary. These provisions are currently included in HCFA's proposed regulations.

We are also concerned about the practicality of the section of the proposal that suggests that special limitations might be appropriate where prevailing Medicare charges are higher than payments made by other purchasers in the same locality. This makes theoretic sense. However, as a practical matter, given the growing prevalence in the private sector of preferred provider organizations and other contracting arrangements in which insurers negotiate price concessions in return for directing patient volume to specific providers, the situations may not be comparable. It also would be difficult and awkward for HCFA or the carriers to collect non-Medicare physician payment screens directly from private payers. Private payers generally consider their payment screens to be proprietary information. We could not support legislative or regulatory proposals that would require private payers to share such screens with the government.

Medicare already requires carriers to reduce Medicare payment screens when they are higher than comparable screens used in the carriers' own private business. We would be pleased to work with the Subcommittee to explore whether that existing authority should be clarified or revised to meet program objectives more effectively.

We support the provision which requires HHS to develop an index to adjust fee schedules to account for geographic differences. We suggest, however, that language be added to permit such an index to be sensitive to market factors. It is not sufficient to base this type of index solely on geographic differences in practice costs and the need to maintain or improve health care access in medically underserved areas. We believe that an index for adjusting a fee schedule should be designed to help assure adequate local rates of physician participation and assignment. This would help to maintain comparable benefit levels among beneficiaries in different parts of the country.

The bill also instructs HHS to study redefining the regions used for developing Medicare physician payment screens. This appears consistent with the Administration's recent budget proposal to reduce excessive geographic variation in Medicare's customary and prevailing charges. We would support these efforts. But, again, we want to stress the importance of recognizing that some local variation in physician service prices is necessary. Finally, although consolidation of certain regions could simplify the Medicare payment program, it should be recognized that such consolidation could increase benefit expenditures as a result of the averaging of different prevailing charge limits. Frequently, the higher prevailing charge levels will be associated with a higher volume of services. Also, additional administrative expenses may be involved.

The bill proposes to simplify payment under HCPCS. We agree that steps to minimize opportunities to overstate the intensity of services are appropriate. The language could be more precise, however. We recommend that the legislation make clear that HHS should take the initiative to collapse codes for certain procedures for purposes of computing payment and utilization screens. This need not involve changes in the procedure codes that physicians use to bill for services. What would change is the Medicare payment screen calculation, which would be based on consolidated data for closely related but separately coded procedures involving comparable risk, complexity, physician time, effort, and skill, and other appropriate factors.

Finally, on this point, we would note that such collapsing of codes for payment purposes already occurs. Carriers are currently permitted to assign single payments for combinations of related procedure codes with prior HCFA approval. This authority should be retained.

The bill would also require that HCPCS eventually be used in billing and paying for all hospital outpatient services. The only hospital outpatient services now subject to HCPCS are laboratory services.

Using HCPCS for billing and paying all hospital outpatient services may well be a legitimate way to improve and fine-tune Medicare's payment program. For example, basing payment for all hospital outpatient services on HCPCS could make the definition of such services more precise. However, because the proposal raises a number of significant policy and technical issues, we strongly recommend that the Committee consider such a major change in the context of an overall legislative strategy for payment for outpatient services.

Using HCPCS could add to the complexity and expense of billing and paying for hospital outpatient care. We do not know what effects such a change would have on outpatient delivery and billing practices. In addition, we do not yet know whether there are adequate data on which to develop appropriate hospital outpatient payment screens. Finally, we believe the maintenance of services on a 24-hour basis and the maintenance of some services which cannot finance their costs should not be reimbursed on the basis of CPR or at least on the basis of CPR screens appropriate to physicians' offices.

While this proposal may have merit, it needs more study than we have been able to give it. A study of this proposal should include consideration of the time and expense of converting to such a coding system for hospital outpatient billing purposes and the problems entailed in developing appropriate levels of payment for hospital outpatient services.

Finally, we are concerned about the proposal to phase in adjustments to reflect retroactively office rental costs more accurately in the MEI. While this legislative proposal would have a less immediate and less pronounced effect than the Administration's proposal, neither seems consistent with the intent of the reconciliation act. That is, instead of rewarding those physicians who signed participating agreements with the Medicare program in the past and encouraging physicians to participate in the future, significant reductions in payment screens through retroactive recalculation of the MEI would have the opposite effect. We recommend that only the current effects of moving to a more accurate index for office rental costs be reflected in the MEI for FY 1987.

Congressional Budget Office Options

Both the Congressional Budget Office and Office of Technology Assessment have published reports recently that describe options for changing how Medicare pays for physician services. The CBO report, Reducing the Deficit: Spending and Revenue Options, briefly discusses three fee schedule options that could reduce Part B expenditures. The first option appears to involve the development of a national fee schedule -- with adjustments for local cost-of-living differences -- based on average allowances. This fee schedule would be in place on October 1, 1987. It would also be adjusted over time to correct for some of the payment anomalies discussed earlier in this testimony.

Although we support the fee schedule concept for the Medicare program, we do not support a fee schedule based solely on national averages of allowed charges. A fee schedule with unrealistically low payment levels in certain areas could increase Medicare expenses for beneficiaries by causing more physicians to decline participation or assignment.

We have serious concerns about the other two CBO fee schedule options for the same reasons. The other two options propose to adjust the fee schedule in future years to reflect changes in service volume and economic changes. One option would limit per enrollee increases in physician expenditures to the increase in the MEI with an additional downward adjustment if services increased in the previous year. The other option would apply the increase in the rate of GNP growth instead of the increase in the MEI.

As they are briefly described in the CBO report, we do not believe the latter two concepts provide sound alternatives for Medicare reform. First, there is the practical difficulty of reflecting increases due to changing technology in an index. Second, spending caps and volume adjustments can work well in the context of local closed panel arrangements that give physicians proper financial incentives, management capability, and data. However, applying such caps on an open panel basis would penalize physicians who practice conservatively as well as those who use services less judiciously. Worse, beneficiaries would suffer most. If some physicians provided more services to maintain income and Medicare payment rates fell, fewer physicians would accept assignment. Thus, beneficiary out-of-pocket expenses could increase dramatically, and access to care would suffer.

Office of Technology Assessment Report

The Office of Technology Assessment Report, Payment for Physician Services: Strategies for Medicare, provides a useful framework for reviewing various alternatives and opportunities for physician payment research and reform. At least one of the options, the creation of a physician payment review commission, will be implemented this year. Aspects of other options such as the development of a resource-based relative value scale and the adjustment of payment levels for grossly overpriced services, are being pursued. As I have already indicated in this testimony, we support and encourage the Congress to consider the OTA options of:

- Giving beneficiaries the choice of joining preferred provider plans.
- Adopting an "all-or-none" assignment policy.
- Improving programs to manage utilization.
- Increasing research and demonstration funding for capitation programs, including experiments with geographic capitation, development of quality assurance criteria, and studies of alternative rating methods.
- Constructing fee schedules based on historical charges, with advice from medical and other groups to achieve realistic and market sensitive payment rates, and revising them when resource cost measures are available.

CONCLUSION

Mr. Chairman, in your proposal you have shown that significant steps can be taken, even within the practical and fiscal limits we face on major reform efforts. We would encourage the Subcommittee to review this proposal in light of our specific comments and look forward to working with you on this subject.

STATEMENT BY CAROL LOCKHART, SENIOR RESEARCH FELLOW, BOSTON UNIVERSITY, BOSTON, MA, ON BEHALF OF THE AMERICAN NURSES ASSOCIATION

Ms. LOCKHART. Mr. Chairman, I am currently at the Boston University School of Public Health and teaching, but as of June 1 I am returning to Phoenix, AR, as the executive director of the Foundation for Affordable Health Care.

I am here today on behalf of the American Nurses Association concerning the issue of physician reimbursement. I am accompanied by Tom Nichols, the ANA legislative director.

While many think physician reimbursement is simply a matter between physicians and the Medicare Program, we would like to suggest that it is an issue that concerns more than physicians alone. In light of that, our statement will focus first on opposition to the Administration's fiscal year 1987 Medicare budget request, and secondly on general concerns of the profession regarding physician payment reform and S. 2368.

At the outset I would like to state our support for comprehensive physician payment reform. Physician payment policy under Medicare will not be truly modernized or made fairer in the absence of the enactment of a basic reform plan.

With respect to the administration's budget, it is clear that again this year health policy is being driven by the need to reduce the deficit. Budgetary concerns dictate program changes, and budgetary concerns means only one thing—cutbacks.

In our view, the Medicare Program has taken its fair share in budget reductions already. Since 1981, Medicare has been cut nearly $40 billion. Cuts in Medicare have been disproportionate in relation to other Federal programs, and have comprised 12 percent of all cuts made by the Federal Government.

Medicare, on the other hand, represents 7 percent of the Federal outlays.

The administration's proposed cuts could adversely impact access to services and the quality of those services. Providers cannot be expected to continue to deliver more care to more people for less money. We urge you to reject arbitrary and unfair health cuts.

The administration also proposes a recalculation in the Medicare economic index as a way of reducing costs. They propose an adjustment to correct for an alleged historical overstatement of the housing cost component. We oppose the use of this index as a blunt instrument to hold down physician cost. The MEI reflects a pattern of allowable charges that existed in 1973 for physician services. To correct the problem of an outdated data base, it is not enough to correct only one element in the index, nor is it enough to identify some services that may have been relatively overpriced and lower them. The need is for a more thoughtful revision of the system, with annual recalibration of allowable physician charges using updated relative values.

Section 5 of S. 2368 requires that the adjustment to the MEI proposed by the Secretary be made in two stages. This approach looks to us like an extension of the physician freeze for yet another year. It is not real reform and does not take into account the negative impact on beneficiaries or the participation of physicians.

Rather than propose a retroactive revision of one variable in the index, we should look at all parts of the index and propose an overall improvement in its design and application.

Section 2 of the proposed bill adds six factors for determining inherent reasonableness of charges for physicians. While we are pleased that the bill takes into consideration market forces when determining reasonableness, it considers only the numbers of physicians as the critical factor; it does not consider the availability and role of nonphysician practitioners.

In setting physician fees under Medicare, the market value of services by other providers who compete with or operate adjunct to physicians should also be considered. If other practioners provide services similar to physicians at a different price, that should be taken into account when determining reasonableness.

We should not ignore the charge experience of other nonphysician practitioners.

With respect to relative value scales, we are pleased that the bill recognizes the necessity of including the contributions of nonphysician practitioners when setting physician's fees. However, we are concerned that the modifications are too narrowly focused and address only the problems relating to medically-underserved areas. This does not reflect the value of other practitioners enough. The value of nurses and others who work with physicians should not be counted merely through variations in geographic charges; other factors should be considered, such as variations over time, specialty, skill requirements and skill levels, education, and experience. All of these should be factored into the calculation of relative values.

We urge the committee to take account of the many different personnel with varying skills and the myriad roles they play in what we call health care.

Our final concern is the changes in physician payments be constructed so as to improve the incentives which foster quality services at reasonable cost. Included in those incentives should be a consideration of the most cost effective combination of personnel. Nurses reduce the need for physician input when they act as nurse-anesthetists, nurse-midwives, and assistants in the performance of a host of technological services. In all of these circumstances, their participation in the service and the calculation of its value should be taken into account in setting the fees in what is now often called simply "physician services," but which in fact include services provided by nurses.

Additionally, the prospective payment of hospital care must also be taken into account in physician payment reform. At present, a hospital is rewarded financially when it uses the services of a physician paid under part B, rather than those of a nonphysician whose services must be covered under the DRG payment. When a hospital employs a nonphysician, the hospital increases its costs but not its income from Medicare. When a physician is used, that use is not a cost to the hospital, and Medicare pays the physician. The result is that total program costs increase. Such perverse incentives in the payment system are permitted to occur even when a nonphysician would be paid at lesser rates.

In conclusion, we ask the committee to keep in mind our view that physician reimbursement is an issue that must also consider the value and contribution of other practitioners.

Thank you for your attention.

Senator **Durenburger**. I thank you very much.

Mr. Nelson.

[Ms. Lockhart's prepared statement follows:]

AMERICAN NURSES' ASSOCIATION
WASHINGTON, D.C.

TESTIMONY

of the

AMERICAN NURSES' ASSOCIATION

on

PHYSICIAN PAYMENT

in the

MEDICARE PROGRAM

before the

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

PRESENTED BY

CAROL LOCKHART, R.N.

on

APRIL 25, 1986

1101 14th STREET, N.W., SUITE 200, WASHINGTON, D.C. 20005 — 202-789-1800

Mr. Chairman, I am Carol Lockhart, senior research associate at Boston University School of Public Health, and Executive Director, Foundation for Affordable Health Care in Arizona. I appear today on behalf of the American Nurses' Association (ANA) and its 188,000 members concerning the issue of physician reimbursement. While many think the issue of physician reimbursement is simply a matter between physicians and the Medicare program, we would like to suggest that this issue is broader than compensation for physicians alone. We appreciate this opportunity to offer some of our thoughts regarding this extremely important issue.

We would like to focus our statement on: 1) payment for physician services included in the Administration's fiscal year 1987 budget request with respect to Medicare; 2) some comments on the staff discussion draft bill to provide for improved procedures for payment for physicians' services; and 3) some general concerns of the nursing profession regarding plans for physician payment reform.

At the outset, I would like to state the Association's support of the need for comprehensive physician payment reform to address the existing flaws in the system of reimbursement which contributes to rising Medicare costs. Physician payment policy under Medicare will not be truly modernized and kept up-to-date or the payments made fairer in the absence of the enactment of a basic reform plan. One of the reasons we believe that the Medicare physician payment system needs reform is that, under current policy, the amounts paid under the system are based largely upon the circumstances prevalent some fourteen years ago. No system has been used during this period in setting program payment levels to take into account many of the changing developments in medical care technology, or in the changing patterns of delivering health care services. Since the current payment provisions were enacted in 1972, the composition of the costs of physician services, the way that medicine and nursing is practiced, and the way that hospital care is paid for have all changed. The changes over time in each of these factors calls for improvements in the policies and methodology used to pay for physician's services under Medicare. Furthermore, a new system is also needed to reflect in a timely fashion future changes in the factors that determine physician payments.

MEDICARE BUDGET PROPOSAL

Again this year, health policy is being driven by the need to reduce the deficit. Under this Administration, budgetary concerns dictate what changes are to be made in federal health programs such as Medicare. And budgetary concerns mean only one thing: cutbacks. Recent problems regarding indigent care, disproportionate share hospitals, patients being discharged "quicker and sicker", and reductions in the labor force are ignored under the Administration's formula. All that matters is that reductions must occur, and Medicare is a good place to start.

Mr. Chairman, it is our view that Medicare has done its fair share in budget reductions already, and should not continue to be the victim of such efforts. Since the beginning of this Administration, Medicare has been cut nearly $40 billion, a shocking amount. Over 100,000 jobs have been eliminated from the health industry, a figure that would cause serious turmoil in many industries. Cuts in Medicare have been disproportionate in relation to other federal programs. Since 1981, Medicare cuts comprised 12 percent of all cuts made by the federal government, while Medicare only represents seven percent of federal outlays. This year, we must say that the Administration remains consistent in its desire to treat the Medicare program worse than other programs in the budget. The

President has called for $38 billion in budget cuts, of which $5.2 billion, or 14 percent must come out of the already reduced Medicare account.

One of the main purposes of the prospective payment system (PPS) was to force hospitals to operate more efficiently. Institutions have responded primarily by reductions in length of stay for patients and cutbacks in personnel. However, it is our belief that such cutbacks cannot continue to occur without an even more adverse impact on access to and quality of health care. From our view, there is no more fat left to be cut.

Mr. Chairman, we were recently involved in organizing a coalition of 108 national organizations to oppose the arbitrary budget cuts proposed by the Administration in the Medicare program. That coalition took the following position: "(The Administration's) proposals could adversely impact the quality of services and access to needed health care by elderly and poor patients. Neither government nor providers can be expected to continue to deliver more care to more people for less money. We urge Congress to ... reject such arbitrary and unfair health cuts."

On the physician side of Medicare, the Administration has proposed several changes that would also increase costs to beneficiaries. The ANA has historically been a practitioner group vitally concerned about the welfare of beneficiaries. We reject any additional increases in the amount of money beneficiaries must pay for their health care. Last year, the first day charge for Medicare patients in hospitals rose from $400 to $492; this year, that payment is expected to increase to a staggering $572. This increase is unacceptable, and further payments by the elderly, as proposed in the President's budget, are equally unacceptable. It is our view that any steps to payment reform must not worsen the current financial circumstances in which beneficiaries now find themselves. Regrettably, the Administration seems more interested in cutting spending than in improving the way in which payment for physician services should actually be made or make physician participation in Medicare more attractive. Widespread participation by doctors in the program provides important advantages to older beneficiaries and should be encouraged.

MEDICAL ECONOMIC INDEX

Currently, the maximum reimbursement level allowed by the Medicare program for a particular service is controlled by an index-adjusted prevailing fee, known as the medical economic index (MEI). The Administration proposed to make a fundamental recalculation in the MEI as a way of reducing the costs of the program. Through regulation, they intend to propose an adjustment in the MEI to correct for an alleged historical overstatement of the housing cost component used to compute the index. Rebasing the index by retroactively adjusting the housing factor of the MEI would result in savings for the Medicare program.

We must oppose this attempt to use the reduction of the MEI as a blunt instrument to holding down physician costs.

The Medical Economic Index used now for so many years basically reflects the pattern of allowable charges that existed in FY 1973 for physician's services. To correct the problems stemming from an outdated data base, it is not enough to pick one of the elements in the MEI that may have been calculated improperly and correct that item, nor is it enough to seek to identify some services that may have been relatively overpriced and lower their prices. The need is for a much more thorough and thoughtful revision of the system for annually recalibrating allowable physician charges. The need is to bring these relative values up to date and keep them up to date. To accomplish this result, it will be necessary not only to perform a one-time recalibration but also to develop a new system for updating physician allowed charges from year to year.

Section 5 of the staff discussion draft requires that the adjustment to the MEI proposed by the Secretary to take into account the retroactive revision of the data and statistics relating to office space shall be made in two steps with one-half effective January 1, 1987, and one-half effective January 1, 1988. We must disagree with this approach to physician payment, which would, in effect, simply look like an extension of the physician freeze for yet another year. While this move makes sense with respect to spending reduction, it is not real reform of the system, and does not take into account the impact on beneficiaries or the participation of physicians in the program. Rather than propose a retroactive revision of only one variable in the current index, the Administration should look at all parts of the index, and propose an overall improvement in its application and design. We are concerned that this proposal does very little toward a comprehensive reform of the system.

Again, we would suggest a thorough revision of the current index for calibration and recalibration of physician charges, with updating of charges from year to year. We urge the committee to move toward comprehensive change.

FACTORS DETERMINING REASONABLENESS

Section 2 of the staff discussion draft adds six factors to be taken into account in determining inherent reasonableness of charges for physicians. While we have had only a brief opportunity to review these factors, we are pleased that the bill does recommend that the Secretary take into consideration market forces when determining the reasonableness of payment levels. It is our view that any evaluation of payment reform must look to the current health care markets in which physicians' services are actually provided. However, we are concerned that the bill in one instance seems to consider only the numbers of physicians as the critical factors in determining reasonableness, and does not consider the availability and role of other non-physician practitioners.

In setting fees reimbursed under the Medicare program, the market value of the services of other health care providers in local markets who compete with or operate adjunct to physicians should also be considered. For example, if other practitioners provide services similar to physicians, and offer them at a different price, that information should be taken into account when determining the reasonableness of physician services.

The reasonableness of fees should not ignore the charge experience of other non-physician practitioners. We conclude that the pricing of some physicians' services needs to be set at a level that is reasonable in relation to the amounts paid to other personnel who may alternately provide part or all of the services.

Therefore, we would like to make the following changes in the Committee draft:

> Section (B)(1)(I): after the semi-colon add, "taking into account the prevailing charges of non-physician practitioners";
>
> Section (B)(1)(III): after the word "physicians" add, "and non-physician practitioners".

RELATIVE VALUE SCALE

Because of our views regarding the value of services of all professionals involved in the concept of physician services, we are please that this document recognizes the necessity of including the contributions of non-physician practitioners to so-called physicians' services when setting physician fees. The discussion draft states that, in making recommendations with respect to the application of a relative value scale, the Secretary shall develop an index to be used for making adjustments to reflect justifiable differences in the costs of practice based upon geographic location. In this regard, the Secretary shall collect data with respect to the costs of practice, including data of non-physician personnel costs, for the purpose of refining the index.

However, we are concerned that the apparent purpose of the index is narrowly focused on adjustments intended to mitigate the geographic maldistribution of physicians, or address problems in medically underserved areas. We believe that these concerns about patient access, while very important to any reform strategy, should take into account a broader test of service availability than only the geographic location of physicians or narrowly defined geographic areas.

While we commend the staff draft for its recognition and inclusion of the costs of nursing services in the computation of variations in costs based upon geographic location, we think this does not go far enough in valuing the services of nurses and other practitioners. Any payment system must reflect the value of nurses who work with physicians. That value should not be computed merely through variations of geographic charges. Additional factors, such as variations over time, by specialty, skill level, practice setting, skills required, education, and experience, should also be factored into the RVS. Acknowledgement of variations in geography only fails to take into account other important variables. There is a wide variety of skills required to practice nursing, and these should be factored into the proposed formula. We urge the Committee to take into account the many different personnel involved with various skill levels and a myriad of roles to play in the provision of physician services.

HCFA COMMON PROCEDURE CODING SYSTEM

Section 4 of the discussion draft requires the Secretary to simplify the payment methodology under the HCFA Common Procedures Coding System to ensure that such methodology minimizes the possibility of overstating the intensity or volume of services provided. We endorse the Committee's intention to minimize the shortcomings of the current coding system that encourages unnecessary services. Consolidation of the code is intended to prevent "coding creep", which we believe to be an appropriate change in the payment system.

While the amount paid by Medicare varies depending upon the types of personnel providing the services, the allowed fees should be reasonable in relationship to each other and create the appropriate incentives for selection of the personnel to be used. These incentives should support the use of the lowest cost personnel who can perform the service effectively. To provide the proper incentives, whenever feasible, the services should be packaged for payment purposes with the same payment being made for the entire package of services regardless of the make-up of the care team. Bundling services in this manner means that the organization receiving payment will be financially advantaged by making up the membership of the care team in the most efficient possible manner. Moreover, the program and its beneficiaries will also benefit from these incentives. Furthermore, precautions need to be taken to avoid paying higher amounts for a given service by a team member simply because a physician billed for the service, rather than the service being billed for by another party.

In our view, consolidation of the Code will likely result in an increased incentive to bundle services. If this is the case, we believe health care services will ultimately be provided in a more efficient manner. While it is difficult to predict if such an outcome will occur, this seems to be a worthwhile step in the way of Medicare physician reform.

CONCERNS ABOUT PAYMENT INCENTIVES

The principal concern we have is that changes in physician payments be constructed so as to improve the incentives to provide services in as efficient a manner as possible at high levels of quality. Among the incentives that should be improved is one that would induce the use of the most-cost-effective combination of personnel. As a nursing organization, we have special knowledge of nursing areas that are impacted by this issue. The same issue, of course, applies to other members of the health care team as well, although nurses comprise the most numerous of the professions involved.

Nurses reduce the need for physician input when they act as nurse anesthetists, nurse midwives, and assistants in the performance of a host of technological services, ranging from the taking of vital signs, x-rays, and electrocardiograms to the crushing of kidney stones by lithotripsy. They perform procedures but, more importantly, determine whether the patient is stable or in immediate need of emergency help. They also perform triage and so determine what further care is needed, and they are deeply involved in planning for necessary post-acute care, the need for which has drastically increased with the advent of PPS for hospitals. They can work closely, hand-in-hand with physicians, or they can work quite independently in providing home care, hospice services, or care in rural health service centers. In all these circumstances, their participation in the service -- and the calculation of its value -- should be taken into account in setting the fees, and in determining who is to be paid, in what is now often called simply physicians' services but does, in fact, include services provided by nurses.

The new prospective payment system of paying for hospital care also needs to be taken into account in reforming payment for physicians' services. At present, a hospital is rewarded financially when it uses the services of a physician whose services are paid for under Part B of Medicare rather than a non-physician whose services must be covered under the DRG payment. When a hospital employs a non-physician, the hospital increases its costs, but not its income from Medicare. When a physician is used, that use is not a cost to the hospital, and Medicare pays the physician with the result that total program costs increase. This incentive to use physicians rather than non-physicians is permitted to occur even when the non-physician would be paid at a lesser rate.

The consequence of this counterproductive incentive may be increased cost to the health system to Medicare, and to the patients through higher co-payments. No complete solution to this problem is likely to be developed while the involved physicians' services to inpatients are covered under Part B of Medicare and non-physician services are covered under the DRG System. The Committee should consider various solutions to this problem, including payments to hospitals for inpatient services, or paying both physicians and non-physicians under Part B. Nurse anesthetists, for example, could be paid appropriately in either way.

We are also concerned that discussions of alternative physician payment policies overly characterize virtually all health services only as physician services, solely within the purview of doctors. We would urge the Committee to keep in mind that many Part B services are supplied by other health professions, such as nurse anesthetists and nurse practitioners, and ought to be priced and paid accordingly, whether or not they are supplied under the direct supervision of a physician. We hope that, in proposing any change in physician payment, the Committee will consult with the various non-physician health professionals in the design of appropriate payment reform.

CONCLUSION

It is clear that the time has come for serious physician reform in the Medicare program. We ask the Committee to keep in mind our view that the issue of physician reimbursement is broader than simply paying doctors. The value and contribution of other pracitioners should also be part of any discussion of this issue. While we believe that some elements of the staff discussion draft, if enacted, would be advantageous to the payment system, we would advocate that a more comprehensive physician payment reform package be considered by the Committee. Real reform is needed in the program, and we offer our support and effort in this regard.

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STATEMENT BY RON NELSON, PAC-C, CHAIRMAN, LEGISLATIVE AND GOVERNMENT AFFAIRS COMMITTEE, ON BEHALF OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS, WHITE CLOUD, MI

Mr. NELSON. Mr. Chairman, on behalf of the American Academy of Physician Assistants, I want to thank you for this opportunity to present our views on physician payment reforms under Medicare part B.

By way of introduction, I am Ron Nelson, chairman of the AAPA's Legislative and Government Affairs Committee. I practice in private practice in a rural area in White Cloud, MI, a community of approximately 1,000 residents. Prior to establishing my practice there, there were no physicians in the community.

Mr. Chairman, I will focus my remarks on a few proposals before the committee.

Fee schedules: In the legislation introduced by Senators Dole, Durenburger, and Bentsen, several important recommendations are made with respect to the development of a relative value scale. The academy welcomes these additional recomendations.

In addition to the suggestions made by the sponsors, the academy would also urge the committee to recognize that there are other providers who care for Medicare beneficiaries in medically underserved areas of the country. Any incentives for attracting physicians should also apply to physician assistants and nurse practitioners

Furthermore, we would request that Congress and the administration, in developing a fee schedule, recognize that PA's and NP's do provide physician services, and thus should be taken into consideration in determining the appropriate fee for a service.

Under an RVS system, certain services will be best provided by PA's and NP's. It will be in the best interests of the patient and the physician to have the physician delegate responsibility for service delivery to alternative providers working under the physician's supervision.

Finally, I would like to add that while we recognize the potential for a fee schedule based on a relative value scale as a future reimbursement mechanism for part B services, we strongly support the development of an alternative system based on capitation, which would serve both to moderate payment levels and to limit unecessary utilization.

Limitations on reasonable charges: Providers have long recognized that there are widely varying charges for identical services that cannot be explained by regional differences or practice styles. As an example, Mr. Chairman, I can perform a simple laceration repair in my office in White Cloud for a charge of approximately $50. The same procedure might cost $150 in Grand Rapids or over $200 in Detroit, obviously a wide variation for the same procedure within the same State.

In listing factors which might affect variations in charges, we were concerned that the Department had not come far enough in attempting to look at the potential variables. The Dole-Durenburger-Bentsen bill adds additional factors that should be considered. We welcome these additions.

However, during consideration of any changes, we believe access to quality care should be of paramount importance.

Assistants at surgery: The administration has proposed limiting the types of procedures for which it will pay for assistants at surgery. The academy welcomes this review but respectfully suggests that it has not gone far enough. It is not enough to simply look at what procedures may be unnecessarily using an assistant. You should also look at who is assisting at surgery.

Medicare coverage of PA's as first assistants at surgery can have a significant effect on the amount of money Medicare pays for assistants at surgery, and also improve the quality of care patients receive.

As an example, you can look at a practice here in the Metro Washington area. Virginia Heart Surgery Associates, one of the top cardiothoracic surgery practices in northern Virginia, utilizes PA's as first assistants. In an effort to improve patient care and reduce costs, Virginia Heart Surgery Associates discontinued use of physicians as first assistants by using PA's. By making this change, the first assist charges were cut in half.

Unfortunately, when the practice made this change they found that Medicare would not cover PA's as first assistants.

When PA's assist at surgery, they work with a set group of physicians. By using this team aproach, surgeons are able to shorten the length of time it takes to complete the operation, thus reducing the amount of time the patient needs to be anesthetized. By reducing anethesia time, you reduce morbidity, mortality, and improve the overall outcome, thereby reducing overall costs.

In addition to assisting in the actual surgical procedure, the PA is also involved in both pre- and post-operative care.

Therefore, Mr. Chairman, the academy's recommendation is that Congress and the administration look at not only what types of procedures warrant an assistant at surgery but also look at what type of providers you will pay to assist at surgery.

Medicare coverage of PA services: As you know, Medicare part B covers PA services if they are provided in a certified rural health clinic, HMO, or competitive medical plan.

In September of this year, Senator Grassley and Congressman Ron Wyden introduced legislation to provide Medicare coverage of PA services, regardless of the practice setting. It is important to understand that is is not inconsistent to consider inclusion of PA's in any physician reimbursement proposal you might consider.

PA's unlike other mid-level health practitioners, actually provide physician services under the direct supervision of a physician. We are not seeking independent practice or direct reimbursement for our services.

The findings of the Congressional Budget Office, in analyzing the Grassley-Wyden proposal determined that it would have no short-term budgetary impact.

In addition, CBO found that there was a potential for long-term Medicare savings as a result of covering PA services.

In light of the extreme concern about the fiscal soundness of the Medicare Program, these findings are important.

We are hopeful that Congress will continue the process begun a few years ago and make PA services available to all Medicare beneficiaries. This is a change that makes sense for both the Medicare Program and the people it serves.

The committee is to be commended for its efforts to make some long-overdue changes in the part B portion of Medicare.

I would be happy to respond to any questions.

Senator DURENBURGER. Thank you very much. I will give all of you that opportunity in writing, and I appreciate very much being here today.

The hearing is adjourned.

[The prepared statement of Mr. Nelson follows:]

AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS
1117 North 19th Street • Arlington, Virginia 22209 • 703/525-4200

STATEMENT OF

THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

To

Subcommittee on Health

Senate Finance Committee

Presented by: Ron Nelson, PA-C

April 25, 1986

Summary of Statement:

Ron Nelson, PA-C
Chairman,
Legislative and Governmental Affairs Committee
American Academy of Physician Assistants

Issues:

1. Additional Criteria for Developing a Fee Schedule for Physician Services.

    A. Include PAs and NPs in incentive program for attracting providers to medically underserved areas.

    B. Include PAs and NPs in development of Fee schedule.

    C. Recognize physician delegatory authority for providing services.

2. Limitations on Reasonable Charges.

    A. Access to care should be primary factor in development of "inherent reasonableness" criteria.

3. How and When to Pay for Assistants at Surgery.

   A. Look at Who Medicare is paying to assist at surgery.

4. Reform of the Medicare Economic Index.

   A. Conduct a more comprehensive reform of the Medicare Economic Index so that it is more reflective of actual cost of practice.

5. Medicare Coverage of PA services.

   A. Medicare should cover PA services under Part B, as long as PA is acting under physician supervision.

APRIL 25, 1986

MR. CHAIRMAN, ON BEHALF OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS, I WANT TO THANK YOU FOR THIS OPPORTUNITY TO PRESENT OUR VIEWS ON PHYSICIAN PAYMENT REFORMS UNDER MEDICARE PART B.

BY WAY OF INTRODUCTION, I AM RON NELSON, CHAIRMAN OF THE AAPA'S LEGISLATIVE AND GOVERNMENTAL AFFAIRS COMMITTEE. I PRACTICE IN WHITE CLOUD, MICHIGAN, A COMMUNITY OF APPROXIMATELY 1,000 RESIDENTS. PRIOR TO THE ESTABLISHMENT OF MY PRACTICE, THERE WERE NO PHYSICIANS IN WHITE CLOUD, LET ALONE A PHYSICIAN/PA TEAM. IN FACT, PRIOR TO OUR ARRIVAL, THE NEAREST DOCTOR WAS LOCATED 20 MILES AWAY.

35% OF OUR PATIENTS ARE OVER 65 YEARS OF AGE AND THE MOST RECENT CENSUS TRACKING INDICATES THAT THE 65 - 75 AGE GROUP IS THE FASTEST GROWING SEGMENT OF OUR COUNTY'S POPULATION. FINALLY, I AM PROUD TO SAY THAT THE FEES CHARGED BY OUR PRACTICE ARE 25% LOWER THAN ANY OTHER PROVIDER WITHIN A 50 MILE RADIUS.

THE ACADEMY HAS BEEN ASKED TO FOCUS OUR REMARKS ON 2 TOPICS:

1. ADMINISTRATION AND CONGRESSIONAL PROPOSALS AFFECTING PHYSICIAN REIMBURSEMENT.

2 SENATOR GRASSLEY'S LEGISLATION TO ALLOW MEDICARE COVERAGE OF PA SERVICES.

ADMINISTRATION/CONGRESSIONAL PROPOSALS:

MR. CHAIRMAN, I WILL FOCUS MY REMARKS ON THE FOLLOWING PROPOSALS:

1. ADDITIONAL CRITERIA FOR DEVELOPING A FEE SCHEDULE FOR PHYSICIAN SERVICES.

2. LIMITATIONS ON REASONABLE CHARGES.

3. HOW AND WHEN TO PAY FOR ASSISTANTS AT SURGERY.

4. REFORM OF THE MEDICARE ECONOMIC INDEX.

FEE SCHEDULE:

IN THE LEGISLATION INTRODUCED BY SENATORS DOLE, DURENBERGER AND BENTSEN, SEVERAL IMPORTANT RECOMMENDATIONS ARE MADE WITH RESPECT TO THE DEVELOPMENT OF A RELATIVE VALUE SCALE.

THE ACADEMY WELCOMES THESE ADDITIONAL RECOMMENDATIONS AND COMMENDS THE SPONSORS FOR RECOGNIZING THE NEED TO CONSIDER GEOGRAPHIC MALDISTRIBUTION OF PHYSICIANS, AS WELL AS THE NEED FOR INCENTIVES FOR ATTRACTING PHYSICIANS TO MEDICALLY UNDERSERVED AREAS, WHEN DEVELOPING A FEE SCHEDULE.

IN ADDITION TO THE RECOMMENDATIONS MADE BY THE SPONSORS, THE ACADEMY WOULD ALSO URGE THE COMMITTEE TO RECOGNIZE THAT THERE ARE OTHER PROVIDERS, SUCH AS PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS, WHO CARE FOR MEDICARE BENEFICIARIES IN MEDICALLY UNDERSERVED REGIONS OF THE COUNTRY. ANY INCENTIVES DEVELOPED FOR ATTRACTING PHYSICIANS TO MEDICALLY UNDERSERVED AREAS SHOULD ALSO APPLY TO PAs AND NPs.

FURTHERMORE, WE WOULD REQUEST THAT CONGRESS AND THE ADMINISTRATION, IN DEVELOPING A FEE SCHEDULE, RECOGNIZE THAT PAs AND NPs DO PROVIDE PHYSICIAN SERVICES AND THUS SHOULD BE TAKEN INTO CONSIDERATION IN DETERMINING THE APPROPRIATE FEE FOR A SERVICE. FAILURE TO RECOGNIZE THAT THESE OTHER PROVIDERS CURRENTLY PROVIDE SERVICES WILL LIMIT THE EFFECTIVENESS AND ACCURACY OF A RELATIVE VALUE SCALE METHOD OF REIMBURSEMENT.

WE WOULD ALSO REQUEST THAT A RELATIVE VALUE SCALE NOT BE LIMITED TO MEDICAL PROCEDURES ALONE, BUT ALSO ADDRESS NON-PROCEDURAL SERVICES SUCH AS CONTINUITY OF CARE SERVICES PERFORMED BY PHYSICIAN ASSISTANTS THAT CONTRIBUTE TO PATIENT RECOVERY AND NON-RECURRENCE OF ILLNESS.

UNDER AN RVS SYSTEM, CERTAIN SERVICES WILL BEST BE PROVIDED BY PAs AND NPs. IT WILL BE IN THE INTEREST OF THE PATIENT AND THE PHYSICIAN TO HAVE THE PHYSICIAN DELEGATE RESPONSIBILITY FOR SERVICE DELIVERY TO ALTERNATIVE PROVIDERS WORKING UNDER THE PHYSICIAN'S SUPERVISION. IF YOU DO NOT ALLOW THE PHYSICIAN TO DELEGATE THIS TASK TO QUALIFIED PROVIDERS, YOU RUN THE RISK THAT IT WON'T BE PROVIDED AT ALL.

FINALLY, WE WOULD LIKE TO ADD THAT WHILE WE RECOGNIZE THE POTENTIAL OF A FEE SCHEDULE BASED UPON A RELATIVE VALUE SCALE AS A FUTURE REIMBURSEMENT MECHANISM FOR PART B SERVICES, WE STRONGLY SUPPORT THE DEVELOPMENT OF AN ALTERNATIVE SYSTEM BASED UPON CAPITATION. A FEE SCHEDULE WOULD LIMIT PAYMENT PER PROCEDURE BUT WOULD NOT CHECK UNNECESSARY UTILIZATION. CAPITATION WOULD SERVE BOTH TO MODERATE PAYMENT LEVELS AND LIMIT UNNECESSARY UTILIZATION.

LIMITATIONS ON REASONABLE CHARGES:

ON FEBRUARY 18, THE ADMINISTRATION PROPOSED REGULATIONS DEALING WITH THE 'INHERENT REASONABLENESS' OF CHARGES FOR CERTAIN SERVICES. PROVIDERS HAVE LONG RECOGNIZED THAT THERE ARE WIDELY VARYING CHARGES FOR IDENTICAL SERVICES WHICH CANNOT BE EXPLAINED BY REGIONAL DIFFERENCES OR PRACTICE STYLES.

AS AN EXAMPLE, MR. CHAIRMAN, I CAN PERFORM A SIMPLE LACERATION REPAIR IN MY OFFICE IN WHITE CLOUD AND THE CHARGE IS $50.00. THAT SAME PATIENT CAN TRAVEL TO GRAND RAPIDS AND THE CHARGE MIGHT BE $150.00. THE PATIENT CAN TRAVEL EVEN FURTHER, TO DETROIT, AND THE CHARGE MIGHT BE $200.00. THAT IS QUITE A VARIATION, $50.00 TO $200.00, FOR THE SAME PROCEDURE WITHIN THE SAME STATE.

IN LISTING THE FACTORS WHICH MIGHT AFFECT VARIATIONS IN CHARGES, WE WERE CONCERNED THAT THE DEPARTMENT HAD NOT GONE FAR ENOUGH IN ATTEMPTING TO LOOK AT THE POTENTIAL VARIABLES. THE DOLE-DURENBERGER-BENTSEN BILL ADDS ADDITIONAL FACTORS THAT SHOULD ALSO BE CONSIDERED AND WE WELCOME THESE ADDITIONS.

AS OTHERS HAVE STATED, HOWEVER, WE STRONGLY URGE THE CONGRESS TO CONSIDER THE AVAILABILITY OF A SERVICE WHEN LOOKING AT COST FACTORS. AS THE DOLE-DURENBERGER-BENTSEN BILL SEEMS TO RECOGNIZE, SOME SEEMINGLY 'UNREASONABLE' COSTS MAY BE BECAUSE THERE ARE ONLY A FEW PROVIDERS IN THAT AREA PERFORMING A PARTICULAR SERVICE.

WE SUGGEST THAT CONGRESS AND THE ADMINISTRATION PROCEED IN THIS AREA WITH EXTREME CAUTION AND CONSIDER ALL THE IMPLICATIONS BEFORE MAKING CHANGES. DURING CONSIDERATION OF ANY CHANGES, ACCESS TO QUALITY CARE SHOULD BE OF PARAMOUNT IMPORTANCE.

ASSISTANTS AT SURGERY:

CURRENTLY THE MEDICARE PROGRAM WILL REIMBURSE PHYSICIANS FOR ASSISTING AT SURGERY. IN GENERAL, THIS IS AN AMOUNT EQUIVALENT TO 20% OF THE SURGEON'S FEE. THUS, IF A SURGEON CHARGED $1,000 FOR A PARTICULAR OPERATION AND HE OR SHE WAS ASSISTED BY ANOTHER PHYSICIAN, MEDICARE WOULD PAY THE ASSISTING PHYSICIAN $200.00.

THE ADMINISTRATION HAS PROPOSED LIMITING THE TYPES OF PROCEDURES FOR WHICH IT WILL PAY FOR ASSISTANTS AT SURGERY. THERE HAS BEEN CONSIDERABLE ATTENTION PAID TO THE FACT THAT MEDICARE MAY BE PAYING FOR ASSISTANTS WHEN THEY ARE NOT NEEDED. THE ACADEMY WELCOMES THIS REVIEW BUT RESPECTFULLY SUGGESTS THAT IT DOES NOT GO FAR ENOUGH.

IT IS NOT ENOUGH TO SIMPLY LOOK AT WHAT PROCEDURES MAY BE UNNECESSARILY USING AN ASSISTANT. YOU SHOULD ALSO LOOK AT WHO IS ASSISTING AT SURGERY.

SINCE THE INCEPTION OF THE MEDICARE PROGRAM, THERE HAVE BEEN VAST CHANGES IN THE TYPES OF PROVIDERS WHO PERFORM PARTICULAR FUNCTIONS. ASSISTING AT SURGERY IS A CASE IN POINT. MANY PHYSICIAN ASSISTANTS ARE CURRENTLY ACTING AS THE FIRST ASSISTANT FOR MANY SURGICAL PROCEDURES. THIS IS AN OUTGROWTH OF THE "TEAM" APPROACH TO HEALTH CARE DELIVERY.

MEDICARE COVERAGE OF PAs AS FIRST ASSISTANTS AT SURGERY CAN HAVE A SIGNIFICANT AFFECT ON THE AMOUNT OF MONEY MEDICARE PAYS FOR ASSISTANTS AT SURGERY, AND ALSO IMPROVE THE QUALITY OF CARE PATIENTS RECEIVE.

COST SAVINGS:

AS I MENTIONED, MEDICARE WILL PAY A PHYSICIAN ASSISTING AT SURGERY AN AMOUNT GENERALLY EQUIVALENT TO 20% OF THE SURGEON'S FEE. MEDICARE WILL NOT PAY FOR A PHYSICIAN ASSISTANT ACTING AS FIRST ASSISTANT EVEN THOUGH THE PRACTICE CHARGES CONSIDERABLY LESS FOR THIS SERVICE.

AS AN EXAMPLE OF THE POTENTIAL SAVINGS, YOU CAN LOOK AT A PRACTICE HERE IN THE METROPOLITAN WASHINGTON AREA.

VIRGINIA HEART SURGERY ASSOCIATES, ONE OF THE TOP CARDIO-THORACIC SURGERY PRACTICES IN NORTHERN VIRGINIA, UTILIZES PAs AS FIRST ASSISTANTS AT SURGERY. THIS HAS BEEN THE CASE FOR A NUMBER OF YEARS.

PRIOR TO USING PAs IN THIS CAPACITY, PHYSICIANS WERE USED IN THE 1ST ASSIST ROLE. MEDICARE REIMBURSED FOR THIS SERVICE. IN AN EFFORT TO IMPROVE PATIENT CARE AND REDUCE COSTS, VIRGINIA HEART SURGERY ASSOCIATES DISCONTINUED USE OF PHYSICIANS AS 1ST ASSISTANTS AND BEGAN USING PAs. BY MAKING THIS CHANGE, 1ST ASSIST CHARGES WERE CUT IN HALF.

UNFORTUNATELY, WHEN THE PRACTICE MADE THIS CHANGE THEY FOUND THAT MEDICARE WOULD NOT COVER PAs AS 1ST ASSISTANTS. THIS, DESPITE THE FACT THAT THE CHARGES WERE CONSIDERABLY LESS FOR THE SERVICE.

VIRGINIA HEART SURGERY ASSOCIATES CONTINUES TO USE PAs AND I AM NOT AWARE OF ANY PLANS TO CHANGE; HOWEVER, IT WOULD BE MOST UNFORTUNATE FROM THE STANDPOINT OF THE PATIENT SHOULD THEY BE FORCED TO CHANGE THEIR PRACTICE BECAUSE OF THIS REIMBURSEMENT PROBLEM.

MEDICARE COVERAGE OF PAs AS FIRST ASSISTANTS AT SURGERY CAN HAVE A SIGNIFICANT EFFECT ON THE AMOUNT OF MONEY MEDICARE PAYS FOR ASSISTANTS AT SURGERY, AND ALSO IMPROVE THE QUALITY OF CARE PATIENTS RECEIVE.

QUALITY OF CARE:

WHEN THE PAs WORKING WITH VIRGINIA HEART SURGERY ASSOCIATES ASSIST AT SURGERY, THEY WORK WITH A SET GROUP OF PHYSICIANS. WHEN THE PHYSICIAN AND PA PERFORM A SURGICAL PROCEDURE, IN MANY CASES THEY HAVE PERFORMED THIS PARTICULAR OPERATION OVER 100 TIMES TOGETHER. BY USING THIS "TEAM" APPROACH, THEY ARE ABLE TO SHORTEN THE LENGTH OF TIME IT TAKES TO COMPLETE THE OPERATION, THUS REDUCING THE AMOUNT OF TIME THE PATIENT NEEDS TO BE UNDER ANESTHESIA. BY REDUCING THE AMOUNT OF TIME THE PATIENT IS "UNDER", YOU IMPROVE THE MORBIDITY AND MORTALITY RATES AND LEAD TO A MORE SUCCESSFUL OUTCOME.

IN ADDITION TO ASSISTING IN THE ACTUAL SURGICAL PROCEDURE, THE PA DOES THE PRE-OPERATIVE AND POST-OPERATIVE CARE. THIS PROVIDES GREATER CONTINUITY OF CARE AND RESULTS IN HIGHER QUALITY OF CARE.

BY CONTRAST, WHEN THE SURGEONS USED ANOTHER PHYSICIAN, IT WAS VERY OFTEN WHOEVER HAPPENED TO BE ON THE CHART FOR THAT PARTICULAR DAY. IN SOME CASES, THE ASSISTING PHYSICIAN AND THE SURGEON MAY HAVE WORKED TOGETHER, IN SOME CASES THEY HADN'T. CLEARLY, THE PHYSICIAN WAS VERY QUALIFIED TO ASSIST AT SURGERY, THAT IS NOT MY POINT. MY POINT IS THAT UTILIZING PAs AS ASSISTANTS AT SURGERY IS A VIABLE AND COST-EFFECTIVE WAY OF PERFORMING SURGERY WHICH SHOULD BE RECOGNIZED BY THE MEDICARE PROGRAM.

THEREFORE, MR. CHAIRMAN, THE ACADEMY'S RECOMMENDATION IS THAT CONGRESS AND THE ADMINISTRATION LOOK AT NOT ONLY WHAT TYPES OF PROCEDURES WARRANT AN ASSISTANT AT SURGERY, BUT ALSO LOOK AT WHAT TYPES OF PROVIDERS YOU WILL PAY TO ASSIST AT SURGERY.

MEDICARE ECONOMIC INDEX:

THE OTHER REGULATORY ISSUE WE WOULD LIKE TO ADDRESS IS THE QUESTION OF AMENDING THE MEDICARE ECONOMIC INDEX. AS WAS THE CASE WITH RESPECT TO ASSISTANTS AT SURGERY, WE DO NOT BELIEVE THE PROPOSED REFORMS GO FAR ENOUGH.

THE ADMINISTRATION HAS PROPOSED MODIFYING THE MEDICARE ECONOMIC INDEX TO MORE ACCURATELY REFLECT HOUSING AS A COMPONENT OF THE MEI. WHILE THERE IS A CASE TO BE MADE THAT THE HOUSING COMPONENT NEEDS UPDATING, SIMILAR ARGUMENTS CAN BE MADE FOR OTHER FACTORS INFLUENCING THE MEI. ONE MUST ASK THEN, WHY ONLY THE HOUSING COMPONENT?

THE ACADEMY BELIEVES THAT THE INDEX SHOULD BE AN ACCURATE REFLECTION OF THE ACTUAL COST OF PROVIDING HEALTH CARE SERVICES TO MEDICARE BENEFICIARIES. UNFORTUNATELY, THE PRESENT MEDICARE ECONOMIC INDEX DOES NOT ACCOMPLISH THIS GOAL. THEREFORE, WE RECOMMEND THAT A THOROUGH EXAMINATION OF THE MEI BE UNDERTAKEN, INSTEAD OF THE PIECEMEAL APPROACH THAT HAS BEEN PROPOSED.

MEDICARE COVERAGE OF PA SERVICES:

AS YOU KNOW, MEDICARE PART B COVERS PA SERVICES IF THEY ARE PROVIDED IN A CERTIFIED RURAL HEALTH CLINIC, HEALTH MAINTENANCE ORGANIZATION OR COMPETITIVE MEDICAL PLAN. COVERAGE UNDER RURAL HEALTH CLINICS WAS MANDATED AS PART OF THE RURAL HEALTH CLINIC SERVICES ACT OF 1977. COVERAGE UNDER HMOs AND CMPs WAS INCLUDED IN THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982.

IN SEPTEMBER OF THIS YEAR, SENATOR CHARLES GRASSLEY AND CONGRESSMAN RON WYDEN INTRODUCED LEGISLATION TO PROVIDE FOR MEDICARE COVERAGE OF PA SERVICES, REGARDLESS OF THE PRACTICE SETTING. SINCE THE INTRODUCTION OF THE GRASSLEY/WYDEN BILL, MORE THAN 100 OF THEIR COLLEAGUES HAVE JOINED THEM IN SUPPORT OF THE PROPOSAL AS COSPONSORS. IN ADDITION TO SENATOR GRASSLEY, 3 OTHER MEMBERS OF THE FINANCE COMMITTEE ARE COSPONSORS, SENATORS MOYNIHAN, MITCHELL AND MATSUNAGA.

IT IS IMPORTANT TO UNDERSTAND, MR. CHAIRMAN, THAT IT IS NOT INCONSISTENT TO CONSIDER INCLUSION OF PAs IN ANY PHYSICIAN REIMBURSEMENT PROPOSAL YOU MIGHT CONSIDER. AS I PREVIOUSLY MENTIONED, PAs ARE WORKING AS ASSISTANTS AT SURGERY, SOMETHING HISTORICALLY RESERVED FOR PHYSICIANS. PAs, UNLIKE OTHER MID-LEVEL PRACTITIONERS, ACTUALLY PROVIDE PHYSICIAN SERVICES, UNDER THE SUPERVISION OF A PHYSICIAN. BECAUSE PAs ARE DEPENDENT PRACTITIONERS, THEY MUST BE DISTINGUISHED FROM ANY OTHER PROVIDER OF 'PHYSICIAN' SERVICES WHO MIGHT COME BEFORE THIS COMMITTEE SEEKING MEDICARE COVERAGE. WE ARE NOT SEEKING INDEPENDENT PRACTICE OR DIRECT REIMBURSEMENT FOR OUR SERVICES.

IT IS PRINCIPALLY DUE TO THE DEPENDENT NATURE OF THE PA PROFESSION THAT THE CONGRESSIONAL BUDGET OFFICE, IN ANALYZING THE GRASSLEY/WYDEN PROPOSAL, DETERMINED THAT IT WOULD HAVE NO SHORT-TERM BUDGETARY IMPACT. IN OTHER WORDS, CBO FOUND THAT EXTENDING MEDICARE COVERAGE TO PA SERVICES WOULD NOT RESULT IN ANY SIGNIFICANT COST OR SAVINGS TO THE MEDICARE PROGRAM. IN ADDITION, CBO FOUND THAT THERE WAS A POTENTIAL FOR LONG-TERM MEDICARE SAVINGS AS A RESULT OF COVERAGE OF PA SERVICES.

THE FINDINGS OF THE CONGRESSIONAL BUDGET OFFICE WERE, IN EFFECT, SUPPORTED BY A RECENT REPORT BY THE OFFICE OF PERSONNEL MANAGEMENT DEALING WITH POSSIBLE COVERAGE OF PA SERVICES UNDER THE FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM. OPM FOUND,

> "SINCE PHYSICIAN ASSISTANTS DO NOT PRACTICE INDEPENDENTLY, THE GENERAL NOTION THAT AN INCREASE IN THE NUMBER OF PROVIDERS NECESSARILY LEADS TO AN INCREASE IN OVERALL UTILIZATION OF HEALTH SERVICES SEEMS LESS LIKELY TO HOLD IN THEIR CASE."

IN LIGHT OF THE EXTREME CONCERN ABOUT THE FISCAL SOUNDNESS OF THE MEDICARE PROGRAM, THESE FINDINGS ARE EXTREMELY IMPORTANT. AS YOU KNOW, MR. CHAIRMAN, THE PRINCIPLE OBJECTION TO COVERAGE OF PA SERVICES, OR FOR THAT MATTER OTHER PROVIDERS, HAS BEEN THE QUESTION OF COST.

BUOYED BY THE FINDINGS OF THE CONGRESSIONAL BUDGET OFFICE AND THE OFFICE OF PERSONNEL MANAGEMENT, WE ARE HOPEFUL THAT CONGRESS WILL CONTINUE THE PROCESS BEGUN A FEW YEARS AGO AND MAKE PA SERVICES AVAILABLE TO ALL MEDICARE BENEFICIARIES. THIS IS A CHANGE THAT MAKES SENSE FOR BOTH THE MEDICARE PROGRAM AND THE PEOPLE IT SERVES.

THIS COMMITTEE IS TO BE COMMENDED FOR ITS EFFORTS TO MAKE SOME LONG OVERDUE CHANGES IN THE PART B PORTION OF MEDICARE. SIMPLY CHANGING THE PROGRAM AT THE FRINGES AS HAS BEEN PROPOSED BY SOME, WILL NOT IMPROVE ACCESS OR QUALITY OF CARE. FURTHERMORE, SUCH MARGINAL ADJUSTMENTS COULD, IN THE LONG RUN, HARM PATIENT CARE AND LEAD TO HIGHER PROGRAM COSTS.

I WOULD BE HAPPY TO RESPOND TO ANY QUESTIONS YOU MIGHT HAVE.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]

[By direction of the chairman the following communications were made a part of the record:]

AARP

May 29, 1986

Mr. Edmund J. Mihalski
Senate Finance Committee
219 Senate Dirksen Office Building
Washington, D.C. 20510

Dear Mr. Mihalski:

I am responding to Senator Durenberger's follow-up questions on my presentation of testimony at the April 25, 1986 Subcommittee on Health hearing to examine proposals to modify Medicare's physician payment system. Please see the attached page for the answers to your questions.

I felt it a privilege to testify before Senator Durenberger's Subcommittee on Health.

Sincerely,

Monroe Gilmour/CMc

Monroe Gilmour, M.D.
Member, AARP Board of Directors

Attachment

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
Vita R. Ostrander *President* Cyril F. Brickfield *Executive Director*

Question 1: Does AARP support the provision of S. 2368 which requires hospitals to use the same coding system as doctor's offices for Part B charges?

Answer 1: AARP believes that requiring at the same coding system for all Part B services is a good step. Without consistency in coding, it is difficult to determine the impact of policy changes on beneficiaries and the Medicare program.

Question 2: Your testimony criticizes the inherent reasonableness authority because the Secretary is not required to consider the beneficiary impact that could result from any reduction in overpriced services. How would you define "beneficiary impact" and implement such a requirement?

Answer 2: By beneficiary impact, AARP is primarily concerned about a drop in assignment and higher costs to beneficiaries which would likely result from any reduction in Medicare payments. In order to protect beneficiaries against higher out-of-pocket costs, AARP believes that reductions in Medicare payments for particular services must be accompanied by a limitation on actual charges for those services. We also believe that HCFA should closely monitor the assignment rate for services subject to payment reductions and the participation rates of physician specialties who perform such services.

AAPA
AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS
1117 North 19th Street • Arlington, Virginia 22209 • 703/525-4200

June 5, 1986

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, DC 20510

Dear Shannon:

Attached is Ron Nelson's response to the written questions posed as a result of the April 25 hearing. If we can provide you with any additional information, please let me know.

Sincerely,

Bill

Bill Finerfrock
Director of Federal Affairs

Enclosure

Question:

1. What factors other than those listed in the Medicare Physician Payment Reform Act of 1986 should be considered when determining the "inherent reasonableness" of charges?

As I mentioned in my testimony, the Academy was very pleased with the expansion of "factors" proposed by the Medicare Physician Payment Reform Act. The limited number of factors proposed by the Health Care Financing Administration was distressing.

Despite the expanded criteria, however, we remain concerned that access to care does not appear to be a major consideration. Attempting to define reasonableness is an extremely difficult task. Despite your best efforts, you may find that an overly restrictive definition of reasonableness forces some providers to simply discontinue providing any Medicare service or severely limits the services he or she will provide. Thus, the end result will be that while you may have succeeded in achieving a fair definition of "reasonable", the practical effect has been to decrease patient access to care.

2. Why do you suggest that availability of a service be considered when looking at cost factors?

As indicated by my response to the previous question, achieving a truly fair definition of "reasonableness" by looking solely at cost factors is what can lead to loss of providers in a particular community. Anecdotal information would certainly seem to indicate that one reason Doctors are attracted to particular practice areas or specialties is the reimbursement factor. Will I be reimbursed more for my services if I practice in Dearborn, MI versus White Cloud, MI.?

By taking access or availability into consideration, you may conclude that charging a higher rate (and thus reimbursing a higher rate) for services in "medically underserved" areas is in fact "reasonable" given the desire to get physicians or PAs into these areas.

The PA profession has been successful at improving access to care for millions of people who otherwise might be without health care. We are proud of this tradition and will continue to meet this need. However, we believe that more than "cost" considerations must drive the Medicare program and equal access to quality health care is an important consideration.

American
Psychiatric
Association

1400 K Street, N.W.
Washington, D.C. 20005
Telephone: (202) 682-6000

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June 5, 1986

Shannon Salmon
Subcommittee on Health
Senate Finance Committee
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Ms. Salmon:

Enclosed are my responses to Senator Durenberger's questions on my April 25, 1986 testimony before the Subcommittee on Health hearing to examine proposals to modify Medicare's physician payment system.

Sincerely,

John J. McGrath

John McGrath, M.D.

Enclosure

Follow-Up Questions from Senator Durenberger for John McGrath, M.D.

1. Your testimony states that "modifying the MEI by recalculating housing costs, in particular taking into account rental costs, would be consistent with recent modification to the CPI, but would continue to make the index an inaccurate measure of the health care industry's medical care component of the CPI."

   How would you modify the index to more accurately reflect the cost of providing health care services to Medicare beneficiaries?

Question 1.

The Medicare Economic Index could be modified to more accurately measure the cost of health care services provided to Medicare beneficiaries by reevaluating some of the components. For example, the salaries and wages component is based on the Bureau of Labor Statistics index of hourly earnings of nonsupervisory workers in finance, insurance and real estate. We ask, is this truly the appropriate comparison group? In addition, this segment does not include total compensation, such as insurance and other benefits offered to employees. Thus, we suggest the component may understate the costs of salary and wage expenses and bias the series downward.

The average costs of expense components may in fact vary significantly across specialties and we suggest a distinction should be made within the index for specialty or geographical location. For instance, a 1986 Medical Economics article found that professional expenses of different specialists varied as much as ten percent. These expenses are also likely to vary based on geographical location and the particular specialty of a physician. The components identified might be more accurately measured by more up-to-date surveys conducted at periodic intervals over the course of a year, so that these expenses are not frozen in time, but reflect seasonal variations in costs for physicians.

The operation of the Medicare Economic Index is particularly onerous for the services delivered by psychiatrists. Psychiatry is limited to the same coverage ($250 after coinsurance and deductible), that has been in existence since the inception of the Medicare program. In constant dollars, the reimbursement for psychiatric services has declined substantially in 20 years.

During the years 1976-1986 the MEI evidenced cumulative percentage increases of 80.5% while for that same period, inflation (CPI) showed cumulative percentage increases of 94.2% and the Medical Care Component of the CPI increased 127.1%. A more accurate measure of increases might actually be the medical care component of the CPI.

2. You suggest that the term "substantial economic justification", which is used in my bill needs further definition. Why? How would you further define the term?

Question 2.

APA is concerned not only about the term "substantial economic justification" for moving to a national rate, but also the potential for abuse of this term. As we mentioned in our testimony, we understand HHS's desire to be a "prudent buyer" of health care services, but we do not truly see any justification for moving to a national rate for any procedure. The costs of practice vary from state to state and from locality to locality. Costs — as we noted in our previous answers — also vary across specialties. Therefore, in our view, there can be no justification for moving to national rate.

Moreover, if one were truly to allow HHS to implement change based upon "substantial economic justification" one would need to carefully lay out a process for doing so. Simply publishing the information in the Federal Register would not be enough. A specific panel with physician advisors would be needed initially to define the term. Then, this panel would also need to meet periodically to determine, what procedures could, in fact, be specifically determined to have substantial problems. Specific economic criteria would need to be set, such as prices which deviate from the mean or median for that procedure by more than two standard deviations. We would also suggest that the procedures for establishing "substantial economic justification" be set by the Physician Payment Review Commission.

MEDICAL AND RESEARCH COMMUNICATIONS INC.

10,000 FALLS ROAD • SUITE 300 • POTOMAC, MARYLAND 20854
(301) 983-9774

DANIEL C. MALDONADO, *PRESIDENT*

June 4, 1986

United States Senate
Committee on Finance
Attention Shannon Salmon
Washington, DC 20510

Dear Ms. Salmon:

Attached is the response of Franklin B. McKechnie, M.D., President of the American Society of Anesthesiologists, to the follow-up question from Senator Durenberger.

Sincerely,

Daniel Maldonado
Daniel Maldonado

Enclosure

Follow-Up Question from Senator Durenberger for Franklin B. McKechnie, M.D.

1. I know ASA has been meeting with HCFA officials to discuss the Administration's FY 1987 budget proposal to limit payments for "standby" anesthesia services.

   What is the status of those discussions? Have you reached any conclusions about the definition of "standby" anesthesia?

(C0501)

Beginning in early March, we initiated discussions with HCFA with the aim of establishing a clearly articulated policy on the reimbursement of "standby" anesthesia.

In our discussions with HCFA's officials over the past three months, we presented the following points:

- Serious misunderstandings have resulted from the continued use of the term "standby" anesthesia, resulting in several adverse actions by some Medicare carriers that have direct patient care as well as reimbursement consequences.
- ASA recommended the use of the term "Monitored Anesthesia Care", setting out the recommended elements of care that must be provided in order to justify reimbursement.
- "Monitored Anesthesia Care" is a full medical service to the patient, comparable to cases in which general or regional anesthesia is administered. If all requirements are met, then such care should be reimbursable on the basis of the present relative value guide methodology.
- With regard to cost savings in the Medicare program, we recommended a modification of the anesthesia base unit values for cataract surgery, which will result in cost savings in FY 1987. This recomendation is based on the recognition of changes in the technical and surgical complexity of this procedure, taking into account the existing anesthesia risk and complications associated with cataract surgery. It should be noted that because

of improved surgical techniques, anesthesia time has already been significantly reduced, thereby reducing the levels of reimbursement for anesthesia care.

Recently we wrote to the HCFA Administrator, Dr. Roper, updating him on our discussions with HCFA's reimbursement officials and summarizing our recommendations.

We firmly believe that the recommendations we have put forward set a clear policy for reimbursement of "Monitored Anesthesia Care," as well as providing for the most appropriate adjustment for cataract anesthesiology services. These measures will allow continued provision of medically indicated and necessary anesthesia services to Medicare patients.

Rand
WASHINGTON OFFICE

2100 M STREET, N.W. WASHINGTON, D.C. 20037-1270, PHONE (202) 296-5000

June 6, 1986

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

Dear Ms. Salmon:

Below are my responses to written questions from Senator Mitchell and Senator Durenberger. Rather than retype the questions, I attach copies of them and refer to them by number.

Senator Mitchell

1. The treatment of specialty differentials in Medicare is an important policy issue, but one that has traditionally been left to the discretion of the carriers. Thus some carriers have more specialty distinctions than others.

The issue is a difficult one, since for some procedures, such as an office visit, the specialist's service sometimes reflects the additional training received. For example, when a cardiologist sees a heart patient, the service often is different from when a general practitioner does. For other procedures, the service is the same, and a differential in the prevailing charges is not wise. The cardiologist may also see that patient for medical problems unrelated to the specialty.

My recommendation would be to compile a list of procedures where the additional training generally does not contribute, and direct the carriers not to establish specialty-specific profiles for them. I would not apply this restriction to office visits, however.

HOME OFFICE: THE RAND CORPORATION, 1700 MAIN STREET, P.O. BOX 2138, SANTA MONICA, CALIFORNIA 90406-2138, PHONE: (213) 393-0411

2. The physician reimbursement system is one of many factors that dissuade physicians from practicing in rural areas. Removing that disincentive would make sense, though I would not expect a large impact from it. Whatever course is taken on reimbursement, the problem of physician shortages in rural areas has been diminishing, and is likely to continue to. Research performed at The Rand Corporation has indicated that as physician supply has increased, access to physicians in rural areas has improved substantially.

The disincentive from the reimbursement system could be removed in a number of ways. Prevailing screens could be adjusted upward in rural areas and downward in urban areas so that they differed only by a cost of practice or cost of living index. A more ambitious change would involve the use of much broader areas to develop prevailing screens--even the whole nation--and adjust the screen according to a local cost index.

3. The adjustments that I described in the answer to the previous section would be a step towards making rural practice relatively more attractive to physicians. As I indicated at the hearing, I am skeptical about defining "medically underserved" areas for special treatment because the more the advantages of the designation, the more difficult it is to limit the treatment to those areas with the greatest need. In addition, a major cause of underservice is lack of health insurance. When patients cannot pay their bills, it is hard to make it an attractive area for physicians. As you probably know,

the proportion of the population that has no health insurance continues to grow, and this is a worrisome trend. Finally, I expect that the increasing aggregate supply of physicians is likely to have a substantial effect on increasing the supply of physicians in rural areas, an effect much larger than that of changing reimbursement policy.

Senator Durenberger

1. When I speak of enhancing the market power of beneficiaries, I am referring to creating the conditions whereby a physician's decision concerning fee levels or whether or not to accept assignment will have an effect on his or her caseload. If a physician raises fees and does not experience a decline in caseload, then there is little constraint on fee setting, and beneficiaries would be said to have no market power.

The participating physician category has increased the market power of beneficiaries by making it easier for them to favor those physicians that accept assignment. By providing beneficiaries with a list of physicians that have committed themselves to accept assignment, Medicare has facilitated beneficiaries' taking out-of-pocket costs into account when choosing a physician. More claims have been assigned since the arrangement went into effect, since physicians perceive their caseload to be more sensitive to their willingness to accept assignment.

Additional steps could be taken to make physicians' caseloads even more sensitive to their decision to accept assignment. For example, Medicare could expand the differential in what it pays to participating and nonparticipating physicians. Nonparticipating physicians could be required to disclose to patients in advance the estimated charges that will not be covered by Medicare. HCFA could make more of an effort to explain the notion of participating physicians to beneficiaries, and make it easier for them to obtain directories. If PPOs can routinely provide employees with directories of preferred providers, I do not see why Medicare cannot do the same. Medicare has just as large a stake in its beneficiaries having ready knowledge of which physicians will accept assignment.

I am pleased to have had the opportunity to testify before this Committee on Medicare reimbursement of physicians and to respond to these additional questions.

Sincerely yours,

Paul B Ginsburg

Paul B. Ginsburg, Ph.D.

PBG/rf

Follow-Up Questions from Senator Mitchell for Paul Ginsburg Ph.D.

1. Under the current fee-for-service payment system for physicians under Medicare, prevailing charges for the same service provided by a specialist are often higher than services provided by a general practitioner. This practice appears to be unfair to the general practitioner and to hurt rural areas. Many people in rural Maine rely upon the services of a general practitioner, and do not have access to specialists.

   How can a new reimbursement mechanism be designed which would not penalize the general practitioner who performs the same procedure as the specialist?

2. Existing prevailing charge screens for physicians act as a de facto fee schedule in many areas. Many feel that these fee screens are imbalanced and have encouraged physicians to locate in high fee screen areas, and to treat patients in hospitals rather than outpatient clinics or rural health centers.

   How can the physician reimbursement system be reformed to eliminate the disincentive for physicians to locate in rural areas?

3. For sometime I have been very concerned about the maldistribution of physicians in rural areas. In my

home State of Maine, the Bucksport Regional Health Center has been trying for over two years to recruit a physician with no success.

Can you possibly build into a new physician reimbursement system an incentive for physicians to locate in medically underserved areas as is suggested in the Medicare Physician Payment Reform Act?

(C0494)

Question from Senator Durenberger for Paul Ginsburg, Ph.D.

1. I am interested in your suggestions to minimize the impact of physician reform on beneficiaries. You talk about increasing the market power of beneficiaries. What do you mean? How would it be done?

(C0494)

American Nurses' Association, Inc.
2420 Pershing Road, Kansas City, Missouri 64108
(816) 474-5720

Washington Office
1101 14th Street, N.W.
Suite 200
Washington, DC 20005
(202) 789-1800

Eunice R. Cole, R.N.
President

Judith A. Ryan, Ph.D., R.N.
Executive Director

June 6, 1986

Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

ATTN: Shannon Salmon

Dear Ms. Salmon:

Please find attached our written response to the followup questions posed to Ms. Carol Lockhart in connection with her testimony at the April 25th hearing by the Subcommittee on Health on modifying Medicare's physician payment policies.

We are pleased to have this opportunity.

Yours truly,

Thomas P. Nickels

Thomas P. Nickels,
Legislative Director and Counsel

TPN:jj

Attachment

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FOLLOW-UP QUESTIONS

From Senator Durenberger for Carol Lockhart, R.N.

1. In undertaking physician payment reform, why is it necessary to consider the services of other health care providers?

In undertaking physician payment reform, it is necessary to take into account the effects of such changes on the services of other practitioners, because those other practitioners are in some cases in competition with physicians, and in other cases act as adjunct to physicians. Payment for physicians' services involves more than payment for the activities of the physician alone. In many cases, the services for which physicians are paid are, in fact, delivered by other practitioners.

In the hospital setting, the releationship between physicians and other practitioners may even be more complex and interdependent. Issues of competition and the establishment of the value of physicians' services arise, for example, with respect to nurse anesthetists, nurse surgical assistants and, other non-physician specialists who perform services in the hospital. The importance of other practitioners in determining the value of physicians' services stand out clearly when salaried non-physician employees of hospitals serve as alternates to physicians in the hospital setting. These non-physician costs are now covered by Medicare under the prospective payment system. However, such costs to the hospital are reduced, and hospital margins increased, if physicians replace non-physicians in the performance of certain services that either practitioner may be qualified to provide. Since physician costs -- to provide assistance at surgery, for example -- are paid for separately under Part B of the Medicare, it can be argued that the program may pay for the same services twice -- once through the hospital payment and then again, in the form of payment to a physician. Physicians have a competitive advantage over other practitioners under these circumstances in seeking to provide services in hospitals even though the compensation is higher and the final result is greater cost to the program and to benefificaries. Obviously, changes in physician payment methodologies can affect these incentives.

2. You urge a thorough and thoughtful revision of the MEI. How would you revise the MEI to more accurately reflect the cost of providing health care services to Medicare beneficiaries?

The present construction of the weights used in the MEI implicitly define a representative package of resources used by physicians, once per unit cost nationwide for each expense item is estimated by the Medicare perogram. The current MEI is applied to every specialty and every service, and in every area of the country, even though changes in cost and compensation very widely among the services affected by the index calculations. All of the elements of the MEI -- not just the housing cost element -- should individually and in a composite way reflect accurately changes in the costs of practice and physician compensation levels. However, the present system does not meet this test. Some services have changed dramatically, in some cases becoming less time consuming and simpler -- yet the charges for such services which may have become more complex are also subject to the same average rate derived for use in all physicians' services. This over-simplified approach, using the same weights that existed in 1973 for physicians' services, stands in sharp contrast to requirements for periodic recalibration adopted to make adjustments to prospective payments for inpatient hospital services. The MEI should be redesigned to accomplish comparable purposes; it should be brought up to date, and kept up to date.

AMERICAN ACADEMY OF OPHTHALMOLOGY

OFFICE OF
GOVERNMENTAL RELATIONS

Suite 300
1101 Vermont Ave., N.W.
Washington, D.C. 20005-3570
(202) 737-6662

June 5, 1986

U.S. Senate
Committee on Finance
Attention: Shannon Salmon
Washington, DC 20510

Dear Shannon:

The following are our responses to questions posed by Senators Packwood and Durenberger subsequent to our April 25 testimony on physician reimbursement under Medicare.

1. Does the American Academy of Ophthalmology have specific recommendations regarding the capping or reductions of "overpriced" fees, particularly with respect to cataract surgery?

First, we disagree that cataract surgery fees are "overpriced." We believe that the majority of ophthalmologists have kept their fees at a reasonable level. However, we are aware of those who charge unusually high fees, and would not oppose government actions that would make their fees more reasonable.

We would not favor a cap, since it would be difficult to compute, and experience shows that once in place, caps are seldom if ever adjusted to keep pace with inflation, cost of living, etc. An approach that might be equitable, would be to calculate a statewide average of charges. Then, those whose fees are below average would not be reduced. Those at the average might be frozen, or reduced a small amount, perhaps 2 percent. Those up to one third above average might be reduced an amount of 4 percent, and those 1/3 to 1/2 above average might be reduced a slightly larger amount of 6-8 percent. Those more than 50 percent over average would bear the greatest reduction, perhaps 10-12 percent. In this way, you do not penalize the physicians who have kept their fees at a reasonable level, plus you may realize greater savings by the larger reduction in the higher fees.

2. With respect to the Medicare Physician Payment Reform Act of 1986, you indicate that my bill recognizes regional variations which "we would probably prefer" over a single national fee. Why "probably" prefer? What are the advantages and disadvantages of a regional vs. national fee?

We oppose a national fee because it would not account for the real differences in the marketplace competition, or in the cost of living and cost of maintaining a practice in different parts of the country. Also, a single fee too easily becomes a permanent cap, which we oppose, as stated above.

For the same reasons, we would oppose a single regional fee. That is why we suggest a statewide averaging, with a "sliding scale" approach to reductions.

3. Does the AAO have a position on the development and use of a relative value scale (RVS) as called for in the bill?

Although AAO's Board of Directors does not have a formal policy on relative value scales, the Academy's leaders and staff have cooperated with the various organizations who are conducting RVS studies. We recognize the inequities of the current UCR system, and would like to see a more rational approach to reimbursement.

4. Why should Medicare use the same payment methodology for anesthesia services whether an anesthesiologist administers general anesthesia or "stands by" and monitors the patients when the surgeon performs the local anesthesia?

We are not arguing how or how much Medicare should pay anesthesiologists for their services. Our very real concern is that the payment for stand-by anesthesia will be reduced to the point that we will not have access to physician anesthesia during cataract surgery. We do not believe that a physician anesthesiologist must be present at every cataract operation; however, we urge you not to allow HCFA to cut our access to the physician services. The need for physician anesthesia stand-by during cataract surgery is usually a reflection of the patient's general health risks. By reducing access, you increase the chance that that patient may suffer preventable lifethreatening complications during cataract surgery.

5. You say in your testimony that "There is strong evidence of a highly competitive market in cataract surgery." What is the evidence? You note that there has been an increase in the supply and distribution of ophthalmologists -- has there been a decrease in fees which tells us there is a competitive market for their services.

Our evidence is the migration of ophthalmologists to all parts of the country. According to our manpower distribution studies, there are ophthalmologists practicing in 99 percent of all zip code areas in the country. Indirect evidence of the competitiveness of the cataract surgery industry is the variety of alternative surgery settings, and the number of competing manufacturers and the diversity of their catarct-related surgical products. Market pressures have forced most ophthalmologists to keep down their increases in fees to reasonable levels.

Again, thank you for the opportunity to testify on the subject of physician reimbursement. I hope the above answers are helpful.

Sincerely,

Cindy

Cynthia Root
Director

Blue Cross
and
Blue Shield
Association

1709 New York Avenue, N.W.
Washington, D.C. 20006
202/783-6222

June 6, 1986

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

Dear Ms. Salmon:

This is to respond for the record to Senator Packwood's questions submitted in response to our April 25, 1986 testimony on Proposals to Modify Medicare's Physician Payment System.

Please contact me if we may provide any additional information on this issue.

Sincerely yours,

Alan P. Spielman
Executive Washington Representative

APS:am

Enclosure

Blue Cross and Blue Shield Association
Response to Senator Packwood's Questions
Submitted for the Record for the
Senate Finance Health Subcommittee
Hearing on Proposals to Modify Medicare's
Physician Payment System
April 25, 1986

Senator Packwood: You mention unsupportable extremes in payment rates as being a problem which must be addressed. As a payor for services, I can understand what is meant by unsupportable high payment rates. But I'm not sure how to identify unsupportable low rates? What criteria do you suggest?

Response: An "unsupportable" low payment rate for a physician service could be defined in the following ways:

- A rate at which unacceptably small numbers of physicians accept assignment for that service;
- A rate that would or does result in physicians adopting less efficient practice patterns, such as performing more costly substitute services or additional, supplementary services of questionable necessity; or
- A rate that inappropriately retards the introduction, availability or use of a medically preferred technology or service, because it does not adequately recognize resource costs or other relevant factors.

Senator Packwood: You suggest that you have not developed and implemented cost-effective MR/UR screens because resources have been limited. Will the additional $60 million per year provided in the 1985 reconciliation bill provide the resources needed?

Response: COBRA does provide at least an additional $60 million* in funding for program safeguard activities, such as medical review audit, and third party liability collections for FY 1986. However, according to information provided at a recent Medicare Contractors' Budget Meeting, only $16 million of this $60 million total will be allocated for medical review purposes for FY 1986. Moreover, this $16 million is to be divided among both Part A intermediary and Part B carrier activities.

The Administration's proposed FY 1987 contractor budget would allocate $47 million for Part B medical review. This is an $11.7 million, or 20%, decrease from the FY 1986 amount of $58.7 million. Based on claims growth and inflation, we estimate that $67.2 million will be needed just to maintain the present medical review effort. Thus, if an additional $16 million were added in FY 1987 to only the Part B medical review funding recommendation, the Part B MR/UR budget would not be adequate to maintain, let alone improve, the Part B MR/UR program.

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*A literal reading of section 9216 of COBRA would suggest that $105 million in addition to amounts otherwise appropriated is authorized for program safeguard activities annually for three years beginning with FY 1986. We recognize that there is evidence that suggests that Congress intended in COBRA to add only $60 million to the contractor budget for FY 1986.

Among the improvements that we believe require higher and more stable funding are additional efforts to develop, test and implement MR/UR screens. In particular, adequate funding should be provided to perform post-payment analysis and review of physician billing and practice patterns using Part B claims. The cost-benefit of such analysis and review has been calculated to be much less than for prepayment review (i.e., about 1:1 compared to about 15:1). However, this is a narrow comparison, since the success of prepayment review is heavily dependent upon post-payment analysis and the MR/UR screens that result from it. In this context, better funding for post-payment analysis is an essential investment in the continued success of pre-payment review.

Senator Packwood: Are there any MR/UR screens which you use in your private business that should be used on Medicare claims?

Response: Yes, however, there are no specific MR/UR screens we would suggest at this time for implementation on a national basis in the Medicare Part B program. Generally, when Blue Cross and Blue Shield Plans that are Part B carriers identify effective MR/UR screens for their private business, they recommend to HCFA that they be applied in local Part B business as well. Because the health care delivery environments in which carriers operate vary, it does not always follow that an MR/UR screen that works well in one area will work well in others.

There is a process, which we support, for developing national MR/UR screens involving the MR/UR Technical Advisory Group. This group, which is made up of carrier representatives, meets regularly with HCFA staff and both recommends new MR/UR screens and advises on their implementation. This group also makes recommendations to and advises HCFA on MR/UR activities in general.

In the past, the MR/UR Technical Advisory Group has made many recommendations regarding specific MR/UR screens. Many of these were based on private business experience and analysis and have been accepted or mandated by HCFA for use in the Part B program. A key issue has been the amount of flexibility carriers should have in adopting and applying MR/UR screens. We believe that the most effective administration of MR/UR will occur if carriers have the flexibility to adopt and modify screens to local provider billing and practice patterns. This includes discontinuing screens that have proven to be locally ineffective and, therefore, represent poor use of scarce contractor funds.

Senator Packwood: What advantage is there to an all or none assignment policy?

Response: An "all or none" Medicare assignment policy would have two key advantages over the current policy whereby physicians can either accept assignment selectively or sing a participating agreement to accept assignment on all cases. First, the "all or none" policy would be far more predictable and understandable for beneficiaries . Beneficiaries would be able to learn readily which physicians may balance bill and which do not. They would therefore be able to determine in advance the extent of their potential financial liability for the services of participating physicians.

Second, this policy would improve Medicare's potential of increasing Medicare physician participation levels on a voluntary basis. In or view, as both the supply of physicians and beneficiary understanding of this simpler system increased, the advantages to physicians of participating would also increase. This assumes, of course, a program for greater marketing of the participation concept to beneficiaries. This would better position the Medicare program to take further advantage of innovative private sector programs, like preferred provider arrangements, that rely on contracts between payers and providers.

Senator Packwood: Regarding the claims backlog -- What policy have you established in your private business as to how fast or slow a claim must be paid? What is your average time from claim receipt to check mailing? How does that compare with Medicare?

Response: In a strict sense, no precise comparison can be made between how quickly Medicare and private business claims are processed and paid. The Medicare program is a uniform program with identical benefits for all claims. In addition, a relatively high percentage of Medicare claims are filled out by beneficiaries and often require additional information before they can be processed successfully.

In contrast, private business programs are not uniform. Each Blue Cross and Blue Shield Plan handles claims from hundreds of different groups with different benefit programs, often subject to different cost containment and other controls, like pre-admission review and second surgical opinions. Moreover, because of high physician participation rates and provider relations support, most claims are "clean." Policies on how fast or slow a claim should be paid are determined by individual Plans taking into account the private market environment. The speed at which claims are paid is a function of several factors, mainly:

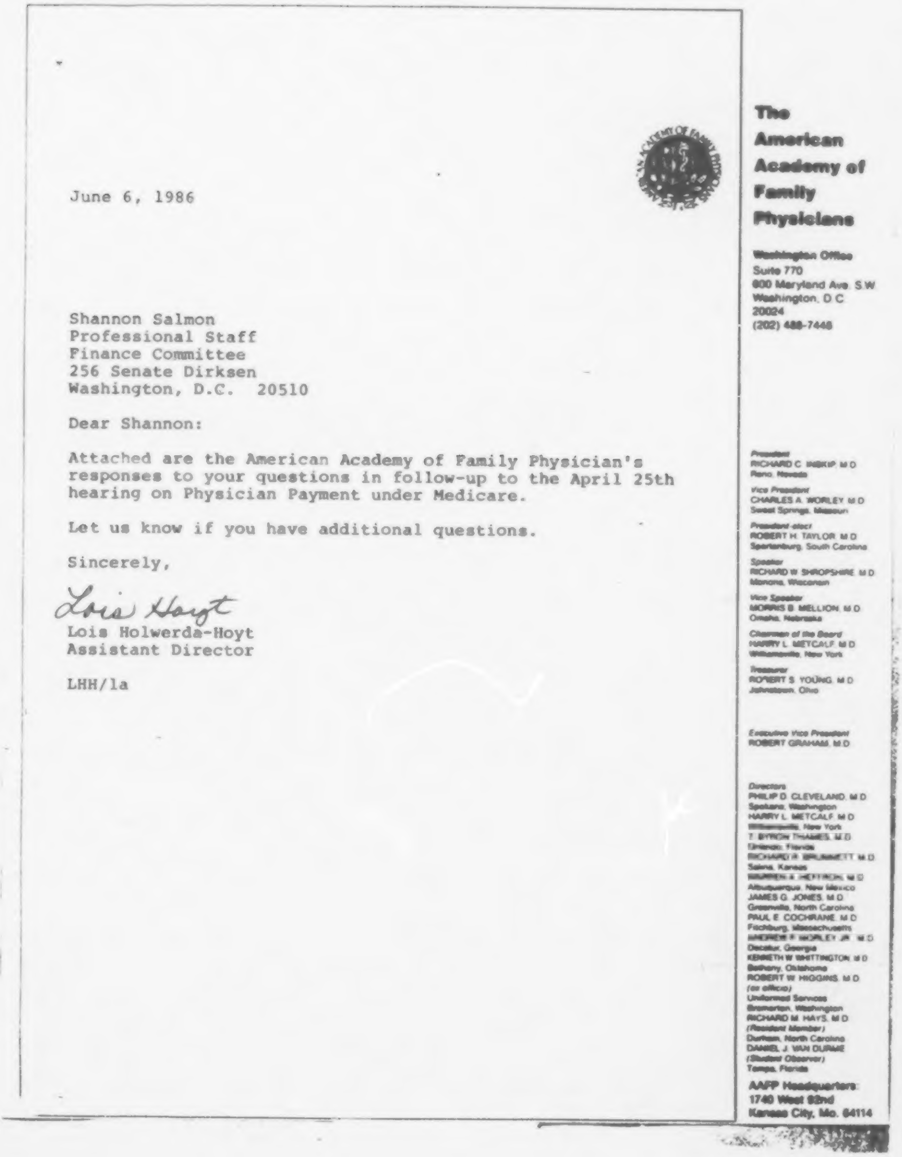
- Claims processing timeliness;
- Negotiated payment arrangements specified in agreements with participating hospitals and physicians -- timely claims payments and, for hospitals, interim payment arrangements are often key elements in these agreements; and
- Frequency of check-writing cycles.

The Association evaluates Plans with respect to the first factor only -- claims processing timeliness. A claim is generally considered "processed" when it is approved for payment or denied. The Association does not collect statistics on the average time it takes to process a claim or to pay a claim (i.e. from claim receipt to check).

To compare the timeliness of Plans' processing of Medicare claims to that of their private business claims special studies are required. Blue Cross and Blue Shield Association surveys show that in early 1985, prior to the Medicare processing slowdown, Plans on balance tended to have similar processing times for both Medicare and private business. Individual Plans did vary, with some processing private business claims somewhat faster and other handling Medicare claims somewhat faster. However, there was no consistent pattern of processing Medicare claims more quickly.

Two frequently used measures of processing time are the percentage of claims processed within 14 days, and within 30 days, of receipt. For 10 sample Plans that process both Part A and B claims, 8 processed a higher percentage of private claims within 30 days than their percentage of Medicare claims processed, while the opposite was true for two Plans. In another sample of 26 Plans that process Part A claims, 13 processed a higher percentage of Medicare claims with 14 days, 7 processed about the same percentage of Medicare and private business claims, and 6 processed a higher percentage of private business claims. In a third sample of 26 Plans that process Part B claims, 7 processed a higher percentage of Medicare claims in 14 days, 9 were about equal, and 10 processed a higher percentage of private business claims, when the data are adjusted for comparability.

Since Medicare claims processing timeliness has slowed considerably since early 1985, it is reasonable to assume that a study done today would show that Blue Cross and Blue Shield Plans are processing private business claims more quickly than Medicare claims.



The American Academy of Family Physicians

Washington Office
Suite 770
600 Maryland Ave. S.W.
Washington, D.C.
20024
(202) 488-7448

June 6, 1986

Shannon Salmon
Professional Staff
Finance Committee
256 Senate Dirksen
Washington, D.C. 20510

Dear Shannon:

Attached are the American Academy of Family Physician's responses to your questions in follow-up to the April 25th hearing on Physician Payment under Medicare.

Let us know if you have additional questions.

Sincerely,

Lois Hoyt
Lois Holwerda-Hoyt
Assistant Director

LHH/la

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Tampa, Florida

AAFP Headquarters:
1740 West 92nd
Kansas City, Mo. 64114

To what extent is Medicare reimbursement policy responsible for physicians exodus from rural areas? To what extent are other factors responsible?

In discussing variations in Medicare payment, the OTA report "Payment for Physician Services" notes the range across localities in payment for specific services is substantial, stating that "four-, five-, and six-fold differences in prevailing charges in 1980 were not aberations." These significant payment differentials when adjusted for the cost of living still showed a three-fold variation which could not be explained by either quality differences or malpractice expense differences.

In fact, according to data from the November 1, 1985 issue of Medical Economics, the overhead for a family physician is higher in rural than in urban areas. Relatively lower Medicare reimbursement, coupled with higher overhead cost, provide a significant economic disincentive for physicians to locate in and remain in rural areas. As was noted in testimony presented to this committee by the National Rural Health Care Association, "rural areas, in general, have a larger percentage of their populations who are elderly or impoverished." Medicare payment policies therefore impact significantly on physicians practicing in rural areas.

Rural practice offers a set of challenges which differs from urban practice and which contributes to the difficulty experienced by many of these areas in attracting and retaining physicians. Many rural areas have a somewhat unstable economy due to the nature of agriculture, and may not have a sufficient economic base to support a physician's practice. Some rural areas do not have ready access to hospitals, resulting in a practice environment for the physician which is isolated from professional colleagues, consultants and continuing medical education opportunities. Many rural areas do not offer the wide variety of cultural activities available in urban centers, nor comparable educational opportunities or employment options for spouses. These are each important factors taken into consideration by physicians and their families in making decisions about where to live and work.

In spite of a Medicare reimbursement policy that is biased against physicians in rural areas, many family physicians do choose rural practice. In fact, a survey of 1985 graduating family practice residents shows that fully one-third (33.9%) located in small towns not within 25 miles of a large city and another 14.8% located in towns of 25,000 or less within 25 miles of a large city, for a cumulative total of 48.7%. With about 14 million people remaining in need of physician services in primary care shortage areas, the elimination of urban/rural Medicare payment differentials would provide an impetus for additional physicians to locate and remain in practice in rural areas, improving access to care for patients residing in these areas, including Medicare patients.

Why is the participation rate so low for family physicians and so high for other specialty areas?

As noted in the April 25 statement of the American Academy of Family Physicians, "it is no coincidence that the specialists with the highest incomes tend to have the highest participation rate." The testimony further validates, through the use of data from Medical Economics and the AMA Socioeconomic Monitoring Service, that family physicians have low incomes relative to other specialists, which have not increased commensurate with the increases in the CPI, and have high office overhead expenses, which are now 48% of gross income (compared to 34% of gross for other specialists).

Stark economic realities have made it difficult for the family physician, who is on the low end of the Medicare reimbursement scale, to become a participating physician, while the choice has far less serious financial consequences for other specialists.

Additionally, the Medicare fee freeze has hit family physicians particularly hard, through the limitation on increases in prevailing charges. As the OTA report "Payment for Physician Services" explains, a much greater proportion of physician visits have approved Medicare charges equal to the prevailing charge level than surgical procedures. Increasingly, the Medicare approved rates for physician visits are determined by the MEI-adjusted prevailing fees than by physician's customery fees. The CBO estimates that with the MEI revision about 56 percent of approved charges would be set by the MEI-adjusted prevailing fees in fiscal year 1987, compared with 50 percent without the MEI revision. Under the CPR system, the prevailing charges set a maximum on the approved charges.

The Medicare specialty differentials pose further problems for family physicians. For example, in areas that recognize more than two specialty distinctions, two or more specialty-specific prevailing charges might be established for the same procedure, resulting in two physicians with identical customary charges having different Medicare approved charges. With Medicare's bias toward higher reimbursement for procedurally-oriented as opposed to cognitive services, family physicians are at a further disadvantage as compared with other specialties. The OTA report succinctly states, "raising approved charges for nonprocedural or ambulatory services would increase assignment rates."

While the participation rate for family physicians has increased slightly since the inception of the participating physicians program, it is not expected to rise appreciably given the current biases against family physicians in the current Medicare reimbursement scheme.

AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 645-5000 • TWX 910-221-0300

JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

June 5, 1986

The Honorable David Durenberger
Chairman, Subcommittee on Health
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

RE: Subcommittee Hearing of April 25, 1986 —
Follow-Up Question - RVS Index

Dear Senator Durenberger:

The American Medical Association appreciated having the opportunity to testify before the Subcommittee on April 25 concerning physician reimbursement issues under Medicare and your bill, S. 2368 — The Medicare Physician Payment Reform Act of 1986. This letter is in response to your follow-up question:

> S. 2368 asks the Secretary of HHS to assess and develop an appropriate index for use in the application of an RVS. "What factors other than those suggested in the bill would you recommend for consideration?"

S. 2368 calls on the Secretary to "develop and assess an appropriate index to be used for making adjustments" in the relative value scale (RVS) that the Secretary is now required to develop by July 1, 1987. The index would reflect "justifiable differences in the costs of practice based upon geographic location without exacerbating the geographic maldistribution of physicians," and "an appropriate adjustment to assist in attracting and retaining physicians in medically underserved areas." This index would be based upon "the most accurate and recent data that is available with respect to the costs of practice." In doing this study, the Secretary would analyze practice costs data relating to: non-physician personnel costs, malpractice insurance costs, commercial rents, and other unspecified factors.

Concerning the proposed index, it must be recognized that distinct differences do exist in the medical care marketplace. The bill appropriately recognizes geographic location differences and requires that malpractice insurance costs, among others, be reflected to establish an accurate measure of the costs of practice. However, practice costs should also recognize the wide variations that exist by practice type as well as locale. Absent a mechanism to account for practice type differences, increases will be based on an index reflecting only average costs. This would be patently unfair in that many practice costs, such as malpractice premium costs, vary substantially by practice specialty. Application of an index that fails to recognize varying practice in a locality could unduly benefit some, unjustly penalize others, and generally fail to serve as an accurate measure of practice costs except for the mythical "average" physician. To avoid such a result, we recommend that Section 3 be amended by adding the phrase "and practice type" into the proposed new paragraph (4)(A)(i) after the phrase "geographic location".

The AMA believes that the elements of practice costs listed in S. 2368 are appropriate factors for gauging certain costs of practice. However, we believe that factors in addition to those set forth in the bill, non-physician personnel costs, malpractice insurance costs, and commercial rents, should be considered. We recommend adding the following factors: other insurance costs, office costs (such as facility and general office supplies), medical equipment costs, and medical supplies. We also believe that the non-physician personnel costs should reflect costs in the medical care sector, not the service industry at large.

The methodology to accomplish the second goal set forth in S. 2368 for the index, "to assist in attracting and retaining physicians in medically underserved areas," must be questioned. While incentives to alleviate maldistribution can be appropriate, we question the use of Medicare reimbursement for this purpose.

The AMA appreciates this opportunity to respond to your question. If you have further questions relating to the development of an RVS or other health related questions, we will be pleased to discuss them with you.

Sincerely,

James H. Sammons M.D.

James H. Sammons, M.D.

JHS/jb

asim
american society of internal medicine

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REPRESENTING
Internists and
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June 9, 1986

Shannon Salmon
Committee on Finance
Dirksen Senate Office Building
Room SD-219
Washington, DC 20510

By Hand

Dear Shannon:

In response to Ed Mihalski's May 9th letter, to ASIM President T. Reginald Harris, MD, I am enclosing Dr. Harris' responses to follow up questions of Senators Bob Packwood and David Durenberger. These are in connection with Dr. Harris' testimony on behalf of ASIM at the Committee's April 25 hearing on payment for physicians services under Medicare.

Please let me know if ASIM can be of further assistance.

Sincerely

Rick

Richard L. Trachtman
Governmental Affairs Representative

RLT:ksk
G-RT-0181

1101 VERMONT AVENUE NW • SUITE 500 • WASHINGTON, DC 20005-3547 • TELEPHONE (202) 289-1700

Follow up Question from Senator Bob Packwood for T. Reginald Harris, MD

1. What criteria would you suggest be used in evaluating whether or not a particular service is "undervalued?" If such a service is being provided in the current market, how can it be underpriced?

The marketplace for health care services is very different from the ordinary market place for goods and services. Patients are not exposed to the usual economic incentives when purchasing physician services because they are in most cases insulated by third party insurance coverage from the effects of such decisions. Therefore the fact that a certain service is currently being provided in the marketplace cannot lead us to conclude that it is appropriately priced.

Physicians can continue to provide services that are reimbursed at relatively low levels by compensating (i.e. providing more of those services that are overvalued). This is what is what is meant by the perverse incentives of the current reimbursement system. In order to make up for the low payment made for office visits, for example, physicians may order additional tests and procedures—services often paid at relatively high rates. An additional adverse result of this payment disparity that exists among physician services is the disincentive offered for spending time with patients as time consuming services are typically those most undervalued.

A decision on whether a given physician service is overvalued or undervalued can only be made through comparison of the level at which payment for it is made with payment levels of other services in the same geographic area. If a service is paid less in relation to the resource costs associated with it (the amount of time required to provide the service, the complexity of the service, physician investments in professional training and education, overhead factors, liability risks, and other appropriate resource cost factors) than other services, it must be concluded that such a service is undervalued in relation to other services.

According to a 1979 study (Stason, W.B., Hsiao, W.C., Toward Developing a Relative Value Scale for Medical and Surgical Services Based on Resource Cost, Washington, DC: Health Care Financing Administration, 1979. (Research contract SSA 600-76-0058)), office visits in comparison to surgical procedures are undervalued by a factor of between two and three. The study concluded that on the basis of the time, skill, effort, training, and expense required to perform each service, the value of an initial diagnostic office visit to a specialist should be 21 percent of an inguinal hernia repair instead of the ten percent now reflected in prevailing charges. This is more than a two-fold discrepancy between the comparative value of the office visit and the usual amount at which it is reimbursed.

To equitably address the problem of misvaluation of physician services, ASIM looks to the development of a resource based relative value scale (RVS) to provide a consensus on more appropriate relative values for physician services. The development of such an RVS is now underway at Havard University under a contract with the Health Care Financing Administration. ASIM believes that Congress should mandate the development and implementation within a reasonable period of time, of a new system of payment for physicians services consisting of a schedule of allowances based on a resource cost relative value scale.

Follow up Question from Senator David Durenberger for T. Reginald Harris, MD

1. The Medicare Physician Payment Reform Act of 1986 calls for simplification of the payment methodology under HCFA's common procedure coding system to ensure that an overstatement of intensity or volume of services does not occur. What suggestions would you make to improve the coding procedure and service definition in order to accomplish this?

ASIM believes that physicians and payors should explore equitable, fair and appropriate ways of "bundling " or "packaging" services to minimize the fragmentation of billed services that may occur under the existing "a la carte" billing and coding system. ASIM will be developing recommendations on appropriate ways of packaging physician services under a fee for service system and will be pleased to share these with you. The Society cautions Congress, however, not to rush into any particular scheme for bundling services, such as ambulatory visit packages that include reimbursement for all ancillary services in a set payment for a patient encounter, until more research and discussion takes place on the most appropriate way to package or bundle services. Packaging of services, if not done correctly, could result in incentives for underutilization of services.

G-RT-0181

American College of Surgeons
FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA 1913
55 EAST ERIE STREET CHICAGO, ILLINOIS 60611 AREA CODE 312 · 664-4050

C. ROLLINS HANLON, M. D., F. A. C. S.
DIRECTOR

June 6, 1986

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

Dear Ms. Salmon:

In a recent letter, you requested an answer to a question pertaining to surgical assistants, which was posed by Senator Durenberger following my April 25, 1986 testimony before the Senate's Subcommittee on Health. In response to that question, I am enclosing the attached "Statement on qualifications for surgical privileges in approved hospitals." Section II of this statement explain the College's position regarding the role and qualifications of surgical assistants.

Thank you for your interest in the American College of Surgeons. Please don't hesitate to call if we may be of further assistance.

Sincerely,

C. Rollins Hanlon, M.D., F.A.C.S.

Enclosure

EM:MAY

Follow-Up Question from Senator Durenberger for C. Rollins Hanlon, M.D., F.A.C.S.

1. While I understand that a primary surgeon may need assistance during the performance of a procedure, in some cases such assistance can be (and is) provided by a surgical technician and/or an operating room nurse.

   What is the College of Surgeons position regarding when an assistant-at-surgery is necessary and what qualifications should the assistant have?

(C0500)

American College of Surgeons

Statement on qualifications for surgical privileges in approved hospitals

In June 1976 the Regents of the American College of Surgeons approved the following statement and directed that it be sent to the Joint Commission on Accreditation of Hospitals (JCAH). The statement has been under review in the JCAH for more than eight months, during which time efforts have been made under other auspices to prepare statements on delineation of hospital privileges at variance with the ACS statement.

In view of the long lag between initial consideration of material for incorporation into JCAH standards and interpretation, the Regents have directed publication of this Statement on Qualifications for Surgical Privileges in Approved Hospitals in the ACS BULLETIN. *This will make the material readily available to the thousands of staff members and administrators in approved hospitals, many of whom direct queries on such matters to the College.*

In February of 1983, the Regents updated Section II, Qualifications of the First Assistant in the Operating Room. As with other standards and interpretations, this statement may be further updated in the future.

C. Rollins Hanlon, MD, FACS
Director, ACS

I. Qualifications of the responsible surgeon

Eligibility to perform hospital surgical procedures as the responsible surgeon must be based on an individual's education, training, experience, and demonstrated proficiency.

A. ACCEPTABLE EDUCATION WILL CONSIST OF GRADUATION FROM A MEDICAL SCHOOL APPROVED BY THE COUNCIL ON MEDICAL EDUCATION OF THE AMERICAN MEDICAL ASSOCIATION, OR FROM A FOREIGN SCHOOL ACCEPTABLE TO THE MEDICAL LICENSING BOARD OF THE STATE*, PLUS EDUCATION LEADING TO QUALIFICATION AS A SURGICAL SPECIALIST.

B. A "SURGICAL SPECIALIST" IS DEFINED AS A PHYSICIAN WHO:

(a) is certified by an American surgical specialty board approved by the American Board of Medical Specialties; or

(b) by reason of his education, training, and experience, has been judged eligible by such a board for its examination; or

(c) is a Fellow of the American College of Surgeons; or

(d) has obtained, in a country outside the United States, graduate surgical education which satisfies the training requirements for Fellowship in the American College of Surgeons.

It is recognized that surgical procedures may also be performed by physicians who do not meet this definition, under the following conditions:

(1) a physician who received the MD degree prior to 1968 and who has had full surgical privileges for over five years in a hospital approved by the Joint Commission on Accreditation of Hospitals where most of his surgical practice is conducted; or

(2) a physician who renders surgical care in (a) an emergency, or (b) an area of limited population where a surgical specialist is not available; or

(3) a physician who has just finished formal training in an approved surgical residency program as defined in his specialty, for whom the appropriate surgical board has not yet determined eligibility.**

A resident in training in an approved surgical program, under supervision, may provide surgical care as determined by the surgical staff.

C. THE GRANTING AND CONTINUATION OF SURGICAL PRIVILEGES WILL BE BASED UPON THE STAFF MEMBER'S RECORD OF DEMONSTRATED PERFORMANCE AS EVALUATED BY AN ESTABLISHED HOSPITAL PEER REVIEW MECHANISM AND MEDICAL AUDIT.

Requests for privileges not generally associated with the field in which the applicant has been trained must be specifically requested and documented with evidence of appropriate training and experience.

In certain geographically isolated and sparsely settled areas, fully trained surgeons in various fields may not be available. The performance of certain surgical procedures, especially of an emergency nature, by a physician without special surgical training may be in the best interest of the public in that area. The medical staff and the governing body of hospitals in such areas should periodically review the quality, the number, and

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**Although not recognized by the American College of Surgeons, certain state and federal laws may also require recognition of other types of health education.*

***Ordinarily, this would not exceed one year plus the board's practice requirement, if any.*

the variety of surgical procedures being performed, as well as the surgical referral policies of the staff. It is possible that the referral pattern in surgical care is such as to discourage the application of properly trained and qualified surgeons for staff membership.

II. Qualifications of the first assistant in the operating room (revised February 1983)

The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical functions which will help the surgeon carry out a safe operation with optimal results for the patient. This role will vary considerably with the surgical operation, specialty area, and type of hospital.

In some hospitals in this country, there may not be specifically trained and readily available surgical assistants in the operating room. The first assistant's role in such institutions has traditionally been filled by a variety of individuals from diverse backgrounds. Designation of an individual most appropriate for this purpose within the by-laws of the medical staff of the hospital is the responsibility of the surgeon.

The American College of Surgeons supports the concept that, ideally, the first assistant to the surgeon at the operating table should be a qualified surgeon or resident in a surgical education program approved by the appropriate residency review committee and accredited under the Accreditation Council for Graduate Medical Education. It is a principle of surgical education and care that residents at appropriate levels of training should be provided with opportunities to assist and participate in operations. Other physicians experienced in assisting the responsible surgeon may participate when a trained surgeon or a resident in an accredited program is not available.

Attainment of this ideal in all hospitals is recognized as impracticable. In some circumstances it is necessary to utilize appropriately trained nonphysicians to serve as first assistants to qualified surgeons. Surgeon's assistants (SA) or physician's assistants (PA) with additional surgical training may be employed if they meet national standards. These individuals are not authorized to operate independently.

Certified surgeon's or physician's assistants must make a formal application for appointment to the hospital, which should include:

(1) an outline of their qualifications and credentials;
(2) stipulation of their requests to assist in a surgeon's practice including assisting at the operating table;
(3) indication of the surgeon who will be responsible for the performance of the SA or PA;
(4) review and approval of the qualifications of the SA or PA by the hospital board.

Registered nurses with additional specialized training may also function as first assistants to the surgeon at the operating table in those situations or hospitals where more completely trained assistants are not available. By doing so, however, the size of the operating room team should not be reduced; the assigned nurse should function solely as the first assistant and not also as the scrub or instrument nurse. Similarly, surgical technologists may function as first assistants in the absence of more qualified individuals.

Practice privileges of those acting as first assistants should be based upon verified credentials reviewed and approved by the hospital credentialing committee. Registered nurses choosing to act as first assistants must be within the defined limits of their state nursing practice act.

III. Surgery by persons not holding medical degrees

A. DENTISTS

The policy of the American College of Surgeons has been well discussed and outlined in the College BULLETIN *(May 1970, page 14)*. Important features of this policy are:

(1) The Division of Oral Surgery will be under the overall supervision of the surgeon-in-chief of the hospital or the chairman of the appropriate surgical department. In non-departmentalized hospitals, the Division of Oral Surgery will be under the Chief of Staff, or a designated committee.

(2) The surgeon-in-chief, the departmental chairman, or the designated committee has the authority and responsibility for recommending to the governing board of the hospital who shall, or shall not, do operative procedures.

(3) In the total care of patients with injuries in multiple regions, or complicated medical-surgical problems, the oral surgeon may be an essential member of the team and may act independently in his own area of special competence. In instances requiring a team approach for the management of injuries in multiple regions, or extensive and complicated medical-surgical problems, the surgeon who is captain of the team, and has final responsibility for the care of the patient, must be an MD.

B. PODIATRISTS

(1) Podiatrists must be qualified and licensed. They may admit patients to the hospital in collaboration with an MD who shall be responsible for the overall aspects of the patient's care throughout the hospital stay.

(2) Surgical procedures performed by podiatrists must be under the overall supervision of the chief of the appropriate surgical service.

(3) Operative procedures will be limited to the foot and toes. The type and extent of operative procedures to be performed by podiatrists will be determined by the chief of surgery upon the advice of members of the surgical staff.

20M-3/83

AMERICAN ACADEMY OF FAMILY PHYSICIANS

STATEMENT ON S.2368

TO SUPPLEMENT APRIL 25, 1986 STATEMENT

The American Academy of Family Physicians would like to offer the following comments on S.2368, introduced on April 24 by Senators Dole, Durenberger and Bentsen, to be included with our April 25, 1986 statement on physician reimbursement. We would like to commend the Senators for recognizing the need for improvements in Medicare payment for physicians and on their efforts in this regard. In particular, we appreciate their sensitivity to the issue of undervalued services, which we have addressed in greater depth in our written statement previously submitted to the committee. The bill would move toward resolution of some of the inequities in the current Medicare system, as well as look to the future reform of the system through development of a relative value scale.

Section 2 of the bill addresses the inherently reasonable criteria and regulatory procedures to be used by the Secretary of HHS in implementing regulations to limit reasonable charges. This section lists six factors that the Secretary may consider in determining the application of the inherent reasonableness limitations. We believe it is very appropriate for the Secretary to take into account prevailing charges that are significantly in excess of or below prevailing charges in other comparable localities. We would also suggest modifying subparagraph Sec. 2(a)(B)(i)(VI) to read, "the prevailing charges for a service under this part are substantially higher or substantially lower than the payments made for the service by other purchasers in the same locality." We are concerned however, that Sec. 2 does not direct the Secretary to identify and correct such inequities. Since, as is mentioned in our earlier statement, the Administration has already concluded that there are virtually no deficient payments, we believe that the intent of S.2368 to address inequities of a deficient nature, will not be accomplished without a specific mandate to this effect.

The AAFP supports the procedures calling for a 60 day public comment period and involvement of the Physician Payment Review Commission which will help ensure that the Secretary has access to comments from a wide range of knowledgeable sources prior to making final decisions.

Section 3 of S.2368 further expands upon the RVS development language in COBRA and defines factors to be taken into account in developing an index. The AAFP is concerned that any new fee schedule which is modified by an index based on geographic differentials, as called for in this section, would continue to promote disincentives for physicians to practice in rural areas. Such differentials have created a shortage of physicians willing to practice in rural areas and reduced beneficiary access to health care. Equal fees would eliminate this disincentive.

We have several questions about the intent and implications of Section 4 regarding the development and use of the HCFA common procedure coding system. Simplifying the payment methodology by reducing the number of codes, for example, could result in physician payment which does not reflect accurately the level of services actually provided to the patient. We recommend this proposal be developed more thoroughly by the committee rather than leaving its interpretation to HCFA.

Section 5 modifying the administration's proposal to adjust the Medicare Economic Index for physicians' services with a two-year phase-in, unfortunately does not alleviate the concerns raised by the AAFP in our earlier statement that the MEI historically lags behind inflation and has not truly reflected the actual cost of practice. This has created a disparity between Medicare prevailing charges and actual fees charged by physicians. Low prevailing charges have particularly affected reimbursement for services provided by family physicians. Retroactive adjustment of the MEI in both the Administration's proposal and S.2368 will exacerbate the existing problem by allowing the rate of increase in prevailing charges to fall even further behind the actual increases in the cost of treating patients. We therefore urge you to reject plans to recalibrate the MEI.

In summary, the AAFP believes S.2368 contains some good features, particularly those which modify the Administration's proposal on inherent reasonableness and those which attempt to ease the proposed retroactive adjustment to the MEI. We believe, however, the bill could be improved to ensure more equitable reimbursement by an adjustment of unreasonably low charges, eliminating geographic differentials and development of an inflation adjustment to the prevailing charge levels which reflects increases in the actual cost of practice.

April 29, 1986

The Honorable David Durenberger
Chairman
Subcommittee on Health
Finance Committee
U.S. Senate
Washington, DC 20510

Dear Senator Durenberger:

The American College of Radiology, representing over 20,000 physicians and scientists who use radiation to diagnose and treat disease, is pleased to present the following statement on physician reimbursement in the Medicare program for the Committee record.

Diagnostic radiologists and radiation oncologists are physicians. We practice independently, as do the vast majority of other physicians. We practice in private offices and hospitals, providing direct services to patients. We believe any change in the physician payment mechanism must be applied uniformly to all physicians - specialists, primary care physicians and consultants.

Like all other physicians, we are concerned about the future of the Medicare program. We appreciate the dilemma facing the Congress as you strive to reach a delicate balance between the cost of health care in the United States and continuation of the superior quality and availability of health care for our elderly citizens.

We are, however, concerned with the debates over the value of procedural versus non-procedural medical services. Physicians are obligated to provide the best care possible to all patients based on individual need. We do not believe there is value in attempts to identify certain procedures as more "caring services" based on whether or not technology is used in treating the patient. We believe that all medically necessary physician services are caring services regardless of the physician providing the care or the technology employed in treatment or diagnosis.

The American College of Radiology encourages the Subcommittee to recognize that there may not be a single solution to physician payment reform. In the private sector and in the government's

AMERICAN COLLEGE OF RADIOLOGY
1891 Preston White Drive, Reston, Virginia 22091 (703) 648-8900

Medicare and Medicaid programs there are many different payment and delivery mechanisms. The fact that there are many different approaches to health care delivery strongly suggests that the needs and demands of the patient population cannot be met with a single solution. We believe that any modification to Medicare's physician payment mechanism should preserve the direct relationship between the physician and patient.

The Congress, in establishing Medicare Part B coverage for physician services, provided for a mechanism to pay the "reasonable charge" for a service to a beneficiary. Those who feel the current "usual, customary and reasonable" charge mechanism has failed should recognize that Congress also provided for a way to assure that payments for Medicare physician services are "inherently reasonable." We believe, that the inherent reasonableness rule, properly used, can faciliate necessary modifications to Medicare payments. We strongly recommend use of currently available mechanisms to modify the physician payment scheme under Medicare.

Proponents of change in the way physicians are paid for their services to Medicare beneficiaries point to the dramatic increase in the costs of these services over the last few years. We believe that much of the increased cost for physician services in the Medicare program has come about through increased utilization of services rather than direct increases in the costs of individual services. The nationwide voluntary freeze on fees by physicians and the mandated freeze on Medicare fees under the Deficit Reduction Act of 1984 have assured that physician payments under Part B of Medicare will remain at levels far below fees to non-Medicare patients.

One reason for the rise in Part B costs is the shift of the technical component costs of many Part A hospital services to outpatient settings. Radiologic diagnostic imaging and radiation therapy services are now provided on an outpatient basis to thousands of Medicare beneficiaries. Often these services are provided with modern, efficient and cost effective new technologies that may be unavailible to hospitals because of cost considerations. The convenience of the outpatient setting to the beneficiary is an additional benefit.

Recent proposals by health economists and others would shift many of these outpatient services back to the hospital setting, either through a capitation method of payment or prospective payment mechanism. This shift, with adequate funding to continue an appropriate level of service to beneficiaries, would only move the program expenditure from one trust fund to the other. Such a change without adequate funding could curtail services to elderly patients.

Proponents of this concept state that the prospective payment system caps would reduce Medicare expenditures for these services. We believe they are correct. However, they should recognize that the decrease in expenditures would be at the sacrifice of utilization of valuable services to beneficiaries. We believe that the convenience and economies of providing services to Medicare beneficiaries in the free-standing outpatient setting should be preserved.

The global billing practices of physicians in these settings provide not only a direct and understandable billing method for the patient, but also provide the Medicare program with easily available data to compare costs of services in different settings. The Health Care Financing Administration has authority under current law and regulations to monitor and adjust any of these charges that are not reasonable.

Many proponents of "rebundling" ancillary services with hospital services cite the "traditional hospital-based physician" as the logical provider of service to be included with Part A payment. While this may have been tradition twenty years ago, a greater portion of radiology is no longer hospital-based.

As early as 1967, the American College of Radiology reacted to Medicare requirements by urging radiologists to separate their finances from those of hospitals. Today the vast majority of radiologists, while still serving hospital departments, practice independently in private offices. Even before Section 108 of TEFRA mandated a split in hospital and physician services, over 80 percent of radiologists were practicing independently and billing for their services. Today the number of radiologists practicing in a private office setting has grown substantially. While most radiologists still provide their services to one or more hospitals, a growing percentage are practicing solely in private offices.

We believe that proposals to combine the services of medical consultants, such as radiologists, with hospital services would severely restrict utilization of these speciality services to beneficiaries and stalemate ongoing advances in medical care that have improved quality and made health care services safer for patients. Medical consultants have been responsible for much of the advance in quality of health care.

Limiting access to consultants and specialists through a reimbursement mechanism could dramatically affect the quality of care received by Medicare beneficiaries. If access to a specialist is restricted, primary care physicians will feel pressure to perform many examinations themselves. While some maybe qualified, many are not and the result could be inferior care for the patient. There is the additional danger that some primary care physicians might increase utilization of ancilliary testing for financial reward, performing services that have questionable merit medically.

Any change in the physician reimbursement mechanism for Medicare should retain the concept recognized by the Congress in passage of TEFRA in 1982. All physicians provide direct services to patients, whether they are primary care and attending physicians or consultants and specialists. We believe it essential that this relationship be continued and that Medicare's fiscal relationship with physicians be uniform.

Sincerely,

Joseph A Marasco Jr.

Joseph A. Marasco, Jr., M.D.
Chairman, Board of Chancellors
American College of Radiology

Roy R Deffebach

Roy R. Deffebach, M.D.
President
American College of Radiology

acr

American
Psychological
Association

TESTIMONY OF

Leonard D. Goodstein, Ph.D.

Executive Officer

The American Psychological Association

on behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

before the

UNITED STATES SENATE

COMMITTEE ON FINANCE SUBCOMMITTEE ON HEALTH

on the subject of

PROPOSALS TO MODIFY MEDICARE'S PHYSICIAN PAYMENT SYSTEM

April 25, 1986

The Honorable David Durenberger, Chair

1200 Seventeenth St., N.W.
Washington, D.C. 20036
(202) 955-7600

I am pleased to have this opportunity to present the views of the American Psychological Association (APA) on proposals to modify Medicare's physician payment system. Representing a membership of 87,000 psychologists nation-wide, APA is the largest organization of psychologists in the world.

The issue of physician payment for Medicare is of great importance, in part because Medicare coverage for nearly all services is predicated upon physician direction and supervision. With no change in the current requirements for physician direction and supervision, physician payment will affect not only physicians but also the entire range of health care providers. In addition to this, the influence of the Medicare program on the broader health care system in this country should also be taken into account in discussions of payment reform. The policies and procedures that Medicare uses are significant influences on other government programs and the private sector.

We will briefly discuss the Administration's proposals for physician reform, and then address several issues in the "Medicare Physician Payment Reform Act" introduced by Senators Dole, Durenberger, and Bentsen. We would also like to take this opportunity to express our general concerns regarding methods of paying for professional health care services and the implications of this for the delivery of mental health services.

The Administration's proposals for physician payment are mechanisms for federal budget reduction based on superficial modifications of the existing payment mechanism. Changes such as those proposed for the Medicare Economic

Index, adjustments to the "inherent reasonableness" criteria for certain services, and limitations on post-cataract surgery and the use of assistants at surgery cannot be considered reforms in any significant or comprehensive sense. True reform of physician payment should incorporate a broad view of the current competitive realities and newly emerging professional relationships that are occurring in the health care marketplace.

In this regard, we would like to comment specifically on some of the features of the proposed Medicare Physician Payment Reform Act. We appreciate that the proposal points out the need to consider the competitive environment for health services in setting reasonable charge limits. The proposal, however, states that a market may be considered "not truly competitive because of a limited number of physicians who perform that service." Many health services provided by nonphysicians are competitive to those of physicians. Considering only the number of physicians in an area could easily lead to an inflated price estimate, since many competitive nonphysician services are offered at a different, often lower, rate. Recognizing all competitive health professionals in the establishment of the reasonable charge for physicians services would result in a more realistic price based on the current market. It could also act to encourage the use of alternative professionals for services that can clearly substitute for those of physicians.

We are most familiar with this phenomenon in the field of mental health services. Psychologists' competitive standing with psychiatrists, for example, has been reflected in the passage of state insurance laws and upheld in local and District courts. The 'direct recognition' laws, state insurance statutes that have been passed in 40 states, establish that an insurance plan must reimburse any professional duly licensed to provide a service which the plan covers. These laws have been used effectively for mental health services, and explicitly recognize the role of psychologists in providing those services. States have recognized through these statutes that consumers benefit from a choice between psychologists and psychiatrists for the many identical services they are both trained and licensed to provide. A study on the impact of direct recognition laws showed that psychiatrists' fees were 9 percent lower than they were in comparable areas without such a law. In another study in an area where direct recognition laws assured a more equitable competitive market for mental health services, psychologists were shown to capture 25 percent of the service market of psychiatrists, a clear indication that their services substituted for those of psychiatrists.

Court decisions have also upheld the competitive relationship of psychiatrists and psychologists. In a case upholding Virginia's direct recognition laws, Virginia Academy of Clinical Psychologists et al., v. Blue Shield of Virginia, et al. (624 F 2nd 476 (4th Cir., 1980)), the court opinion states clearly that psychologists and psychiatrists are competitors and "it is not the function of a group of professionals to decide that competition is not beneficial in their line of work (and) we are not inclined to condone anti-competitive conduct upon an incantation of 'good medical practice'."

Because of these facts, we urge you to expand the factors considered in a competitive market for the purposes of establishing reasonable charges to reflect the activities of other health professionals who compete with physicians.

In regard to the proposal for the establishment of a fee schedule for physician services, we have several comments to make. We appreciate the proposal's recognition of the need to incorporate data on nonphysician personnel costs in the refinement of the index used for such a fee schedule. The index should be used, however, to promote the adequate distribution of all health professions and not limited to guarding against a maldistribution of physicians as the proposal indicated. We encourage the Committee to consider a greater use of service obligation mechanisms such as the payback provisions of many health profession support programs including the clinical training program at NIMH to remedy the maldistribution of health care professionals.

In addition, the proposal is not clear regarding what impact physician fee scedules would have on the use of nonphysician health services given the Medicare's requirement for physician direction and supervision for coverage.

We strongly support the proposal to simplify the HCFA common procedure coding system. We consider it inadvisable, however, for procedure descriptions to include indications of which professionals shall perform the services described. The CPT-4 codes, which comprise a major part of the HCFA system, were developed for physicians and therefore incorporate reference to services "provided by or under the supervision of physicians." Some state medical practice laws are such that nonphysicians are reluctant to use codes that describe services in this manner.

We recognize that both service coverage criteria and provider criteria must be satisfied for reimbursement to occur, but approprite authorization and delivery of services is a separate matter from the description of the service provided. If descriptions accompanying the procedure codes were generic, it would facilitate greater flexibility in the use of procedure codes by a variety of qualified professionals, and avoid unnecessary duplication of codes in order to distinguish between physician and nonphysician providers. The CHAMPUS program is a good reference in this matter as it has used the basic procedure codes but deleted reference to professional status in the service descriptions.

In addition to these specific concerns with the Administration's proposals, and on the proposed reform act, we would like to take this opportunity to comment in general on methods of paying for professional health services and the implications for the delivery of mental health services. Given the physician direction requirements for coverage of services in Medicare, a matter of grave concern to us is the impact of establishing a physician payment schedule that could jeopardize the provision of services by nonphysician professionals. The prospective payment system established for Medicare hospital services has resulted in great changes in the relationships between health professions and hospital settings.

Hospitals under the prospective payment system (PPS) have strong fiscal incentives to minimize the provision of inpatient services and to use Part B physician services whenever possible. Our information in this regard is from the experience of psychologists who are directly affected by the prohibition of unbundling in PPS. A striking example involves a hospital in the state of Oregon which literally jettisoned its entire psychology department and all the psychologists connected with it when the new Medicare system was implemented. Over a year later, the hospital approached the clinic, which its former psychologist employees had established nearby, and proposed a contract with them which soon surpassed the service level they had provided in the hospital. This is an optimistic scenario; there are also numerous examples where psychologists have been categorically excluded from providing services to inpatients by hospitals for whom fiscal priorities have replaced clinical concerns. The Committee is already familiar with our testimony on this issue regarding the special impact of this mechanism on the ability of psychologist medical school faculty to generate their fair share of clinical revenues.

We can easily foresee just such a disruptive process occuring if physician payments are established that put the physician at financial risk for health services in the same manner that hospitals are now at financial risk for inpatient services. Fiscal incentives could easily replace clinical protocols as a basis for decision making. The phenomenon of minimizing services and length of stay has been a consequence of the implementation of Medicare's prospective reimbursement for hospital services, with the impact on quality of care not yet clearly understood. Surely, it would be better to foresee consequences of this nature in outpatient settings and plan carefully for the sake of the patients who receive health care services under the Medicare program.

APA believes that the health care services which may be delivered by nonphysician professionals could be in direct jeopardy if physicians are assigned gate-keeper roles and fiscal incentives to minimize services are in place. Our concern in this regard is not limited to the specialty of mental health care, but to the entire sector of general health care. The fact that physicians receive minimal training in mental diagnosis and treatment is a cause of great apprehension. Over half of the visits to physicians' offices are for symptoms that have no diagnosable organic basis. Furthermore, there are numerous cases where nonphysician services play pivotal roles in assuring optimal patient response to treatment, such as hastening patient recovery from surgery or illness. With the inadequacy of physician training and the vast numbers of inappropriate visits to physicians, together with added fiscal incentives for minimizing services, procedures must be put in place to assure appropriate referrals to nonphysician providers. Inappropriate treatment and referral by physicians will not necessarily be controlled by motivations to avoid legal liability.

The growing supply of physicians is only one aspect of the current health manpower system. The growth in the number of nonphysician health care professionals is also a significant development in the health care field since the inception of the Medicare program. Psychologists provide an excellent example of this phenomenon. The discipline and practice of psychology as a health profession has grown increasingly sophisticated over the past two decades since Medicare was enacted. However, Medicare is the only Federal health program that has yet to recognize this valuable professional resource in any significant way.

Medicare's coverage for mental health services has remained inadequate and constrained since the program's inception, regardless of the growing evidence of the need for such services by the elderly and disabled whom the program serves. Any mechanism that places physicians in positions of financial risk for service delivery perpetuates and exacerbates existing constraints and does not reflect the multi-disciplinary nature of the mental health service field. When the Medicare program started, physicians had established themselves as the only health profession whose license allowed them unlimited practice privileges across all specialties and settings. Controls were self-imposed and maintained in such a way that physicians themselves often had little latitude for innovative arrangements or organizational structures. Psychologist health service providers were a relatively small group; licensure laws for independent practice were not established nationwide, state insurance laws had yet to recognize the value of mental health services or the licensure status of nonphysician professionals.

The situation 20 years later has changed dramatically: psychologists are now licensed for independent practice in all 50 states and the District of Columbia, and recognized as autonomous providers in all Federal programs except Medicare; state insurance laws mandate the provision of mental health services in health insurance plans, and direct recognition laws facilitate competition among qualified professionals. Yet Medicare's mental health service coverage remains as limited now as it was in 1965, both in terms of its benefit levels and in terms of its lack of recognition of psychologists. In effect, this policy serves to narrow the scope of services available from professionals who have more expertise in specialized areas than physicians themselves. We feel strongly that payment for professional services for the treatment of mental and nervous disorders should use and reinforce the role of multi-disciplinary teams and not predicate payment decisions on one source of professional judgment.

Thank you for this opportunity to present our views on physician payment reform proposals. We look forward to working with the Committee as you continue your deliberations on this issue.

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aamc association of american medical colleges

JOHN A.D. COOPER, M.D., PH.D.
PRESIDENT

(202) 828-0460

May 5, 1986

The Honorable David Durenberger
Chairman, Subcommittee on Health
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Association of American Medical Colleges welcomes the opportunity to submit for the hearing record a written statement on Medicare payment for physician services. In addition to its medical school and teaching hospital members, the AAMC includes 82 faculty societies many of whose members provide professional medical services to Medicare beneficiaries.

General Principles

As new approaches to physician payment are considered, the AAMC urges careful attention to the application of the approach in teaching settings. For more than fifteen years, Medicare officials have been working with Congress and the AAMC to develop a fair and equitable application of the usual, customary, and prevailing system to physicians who involve residents in the care of their patients. The AAMC hopes that any changes in the payment system will address the teaching setting from the beginning. Therefore, the AAMC recommends that the following principles be included in any revised payment system:

- o In a teaching setting, if the level of professional medical services provided a patient by the physician and documented in that patient's record is equivalent to the level of services furnished a patient in a non-teaching setting, then the physician in the teaching setting should be eligible for payment on the same basis as the non-teaching physician.
- o Where a physician service in a teaching setting is eligible for payment, the payment for that service should be determined in the same manner and procedure as payments are determined for non-teaching physicians in the general community.
- o The determination of the level of payments for professional service should not be influenced by the extent to which physicians provide services to non-paying or Medicaid patients.
- o Payments for physicians choosing to practice in teaching settings should not impose requirements which result in artificial or atypical relationships on the provider organization and its medical staff.

The AAMC also believes that special attention should be given to ensuring that any revised payment system does not preclude or discourage resident training in the full spectrum of long-term care and ambulatory care settings.

HCFA Regulations

On February 18, 1986, the Health Care Financing Administration published a proposed rule advocating a procedure for changing, in selected circumstances, the present policies for calculating reasonable charges. The proposed regulation sought to establish a mechanism by which the usual method of establishing a "reasonable charge" for a service can be abridged when it will result in an unreasonably high charge. The AAMC understands that there may be instances in which HCFA's usual formula for determining charges may result in inappropriate levels of payment. For example, the AAMC is aware that new medical technologies and techniques can dramatically affect the time and effort involved in providing services to patients.

However, the AAMC is opposed to the procedure suggested in the proposed regulation. The regulation indicates that HCFA would identify areas in which it suspects Part B compensation is excessive, calculate new payment amounts for these services, and publish proposed regulations to establish those payment amounts. After eliciting comments from the public, HCFA would then publish the final regulation, which may or may not contain changes from the proposed rule. As the agency responsible for Medicare outlays, HCFA is not an objective independent party able to determine what constitutes a "reasonable" outlay for a particular service. If the regulation were adopted as proposed, HCFA would be acting both as the unilateral determiner of the rules for "reasonable payment" under Part B and as the payer, a dual role of judge and plaintiff.

The AAMC believes the interests of the government, patients, and providers would be best served if proposed changes from the current accepted method of fee determination were discussed publicly, and enacted only on advice and consent of a knowledgeable, independent advisory body, which has been established to review such payment issues. This advisory body should have representatives who are providers as well as public and payer representatives. For example, the Omnibus Reconciliation Act created the Physician Payment Review Council This council or a similar body would be an appropriate advisory body to evaluate these payment changes. Therefore, the Association proposed the following alternate process:

- First, if HCFA discovers an instance which it believes warrants deviation from the normal methodology for calculating payments, then HCFA should publicly explain its rationale and provide the data which led it to conclude that the normal payment results in excessive payment rates. This explanation should be published in the Federal Register to give all affected parties adequate notice.

- Secondly, a hearing should be held by the independent body to review HCFA's rationale and information. Others wishing to take issue with HCFA's assertions of excessive payments should be afforded the opportunity to present their information, as well.

- After this discussion has taken place, the independent advisory body should evaluate the information presented and advise HCFA on whether or not to proceed with regulations.

- In those instances in which the advisory body concurs that recalculation of payments is appropriate, the advisory body should elicit suggestions from HCFA and other interested parties regarding acceptable formulae for the recalculations. The advisory body could assess these alternatives and advise HCFA on which method (or methods) to use in drafting proposed regulations.

Conclusion

The AAMC recognizes the present dissatisfaction and unrest with Medicare's usual, customary and prevailing system for determining payments for physician services. While the AAMC does not have a particular payment proposal to recommend, the Association must note that the form and content of any revised payment system for professional services will provide economic incentives that influence the attractiveness of the various specialties and subspecialties. Therefore, change in the payment system must be approached carefully and with demonstration projects so that intended benefits and unintended consequences are understood.

The AAMC appreciates your consideration of these concerns and recommendations and would welcome an opportunity to discuss them with you or your staff.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

Statement
of the
College of American Pathologists
to the
Senate Finance Committee
on
Payment for Physician Services
April 25, 1986

The College of American Pathologists appreciates this opportunity to express the views of pathologists on alternative payment methods for physician services under Part B of the Medicare Program. The College is a national professional medical association representing more than 10,000 physicians who practice the specialty of pathology in community hospitals, teaching hospitals and independent laboratory settings.

A number of options are being considered for modifying the current Medicare Part B payment system for physician services. The problems with Medicare's customary, prevailing and reasonable (CPR) charge system are well documented and we will not restate them. The College believes it would be useful to the Committee to explain how pathology services are characterized for payment purposes under the Medicare program. Medicare regulations divide hospital-based physician services into two categories: physician services to individual patients (e.g. surgical pathology, hematology, blood banking services) which are paid on a fee-for-service basis under Part B; and physician services to the hospital (e.g. quality control, laboratory management) which are paid under Part A. Significant amounts of the pathologists' time and effort are involved in the provision of direct patient care to individual patients and are therefore billed on a fee-for-service basis to Part B.

The provider-based physician regulation eliminated hospital combined billing for hospital-based physician Part B services and requires that these services be separately identified and billed to Part B. This regulation was adopted in 1983 to implement section 108 of the Tax Equity and Fiscal Responsibility Act of 1982. Like other physicians, most of our members are not paid through the hospital for Part B services; instead they direct bill on a fee-for-service basis for services to Medicare beneficiaries as well as to other patients. Therefore, proposals for change in the method of paying for Part B physician services are critically important to our members and the beneficiaries they serve.

The Current Medicare Payment System

Pathologists' experience with the current Medicare Part B payment system - especially the experience of the large number of pathologists who began direct billing since 1982 as a result of the provider-based physician regulation - provide graphic examples of the problems that exist. Some of the clearly inequitable features of Medicare's Part B payment system were addressed by the Congress in Section 9304(b) of the Consolidated Omnibus Reconciliation Act of 1986. Section 9304 provided special adjustments for the hospital compensation-related customary charge (CRCC) profiles that had been put in place for those pathologists who began direct billing after 1982. We appreciate this Committee's efforts in working with the College to provide legislative relief that corrects the inequities associated with the use of CRCCs to pay for pathology services.

The College believes that reform of the Part B system requires careful analysis because of the potential impact on quality, availability and cost of physician services to beneficiaries. Fee-for-service payment has, so far, assured Medicare beneficiary access to high quality medical care. It should not be abandoned in favor of other forms of payment which have not been adequately investigated and tested. While there are many problems with the current system, we believe that precipitous change is not warranted because of the potential for unanticipated adverse effects on patient care.

The Development of Relative Values

The Health Care Financing Administration (HCFA) recently awarded a contract to Harvard University to develop a resource based relative value schedule for physician services. The College supports this initiative because it is a first important step toward resolution of the inadequacies of the current Medicare payment system. An indemnity reimbursement system using resource based relative values could solve many of the problems the current system poses for physicians, beneficiaries and Medicare.

The College is particularly pleased that the 30 month study will include a pathology panel among the 12 panels that have been established to develop relative values based on resource costs. The inclusion of pathology services in the study is significant because prior to 1984 reimbursement data for these services was not consistently and accurately captured by the Medicare program.

COBRA calls for the completion of a relative value scale for physician services by the Secretary of HHS not later than July 1, 1987. The Harvard study is due July 1, 1988. We recommend that current law be amended to delay the due date of the HHS relative value scale so that the Secretary will have the benefit of the Harvard study.

DRG Payment for Hospital-Based Physicians

Investigation of the use of Diagnosis Related Groups (DRGs) as the basis of payment for physician services has raised serious questions concerning the feasibility of this approach. Most observers agree that an "MD-DRG" payment system would be inappropriate for a number of reasons.

First, there are concerns about the ability of DRGs to predict physician resource utilization by individual patients. This weakness of the DRG patient classification system means that DRG payments would likely result in substantial overpayments for services to some patients and underpayments for services to others. Windfall gains to some physicians and unacceptable losses for other physicians would be the cause of additional problems rather than the cure for problems which presently exist.

Second, there are concerns that the financial incentives of an MD-DRG system would adversely affect patient care because of the strong incentive to underutilize resources required for adequate patient care.

It has been suggested that payment for hospital-based physician Part B services to individual patients (i.e. services provided by radiologists, anesthesiologists and pathologists) should be redefined as hospital Part A services and paid to the hospital through the DRG rate. This would be accomplished by recalibrating the DRG cost weights so that the hospital would receive payment and in turn pay physicians for their Part B services. According to the proponents of this approach, this change would be more acceptable to physicians and an easy first step toward MD-DRGs for all physician services to inpatients. We have never expressed this veiw to those who have investigated MD-DRGs. This approach is not acceptable to pathologists, and the College does not believe this approach would be more acceptable to other physicians. The College believes such recommendations are inappropriate and are not based on a realistic assessment of the manner in which pathology services to individual patients are provided.

A review of the research on the use of DRGs to pay for physician services reveals that the application of DRGs to the Part B services of hospital-based physicians has not been carefully investigated. According to these studies, which merged Part A hospital and Part B physician claim data, physician charges for hospital based physicians services such as a radiology, anethesiology and pathology were often unavailable. In fact, the study indicates that the Part B physician claims data that was analyzed contained virtually no Part B pathology bills.

These studies do not address the issue of whether the DRG classification system can predict expected utilization of Part B pathology services. The suggestion to pay for Part B services of hospital-based physicians through a recalibration of hospital cost weights is not based on a sound analysis of technical or operational feasibility.

The College is opposed to payment for pathology Part B services to individual patients through the hospital DRG rate for the following reasons:

1. TEFRA clearly defined those services of pathologists which are identifiable to individual patients and are properly billed under Part B of the Medicare program. The provider-based physician regulation requires separate billing for these services and eliminated the practice of combining the bill for these services with the bill for hospital services. Pathologists have adjusted to this significant change. Most pathologists now direct bill for their services to all patients including Medicare beneficiaries. A reversal of the payment policies put in place by Congress in 1982 is not in the best interest of the Medicare patient the hospital or pathologists. A decision to pay for these services through the hospital will be disruptive to both hospitals and pathologists. It would require substantial changes in contractual arrangements and billing systems. TEFRA and its 1983 implementing regulations substantially altered billing and payment arrangements for pathology services. Many pathologists have only recently assimilated and adjusted to these changes.

2. The DRG is unlikely to be adequate for predicting expected pathology resource requirements. A relatively simple surgical procedure may require complex and time consuming services of the pathologist in reaching a diagnosis. On the other hand, a complex surgical procedure could require relatively less complex pathology services. Determination of the additional DRG amounts that would be paid to the hospital would be difficult. It is probable that such an approach would unfairly penalize some hospital-based physicians and their hospitals and

unfairly reward others because payments would not necessarily be related to the physician resources required by the individual patient.

3. Payment to the hospital for Part B physician services of hospital-based physicians will not encourage more effective and efficient utilization of pathology services. Hospitals do not order or directly control the provision of pathology Part B services. It is also important to recognize that there is no evidence that pathology services to individual patients are inappropriately ordered or over-utilized.

Like other physicians, the pathologist utilizes his or her medical judgement and training to determine what services are necessary for the diagnosis and care of the individual patient. Pathologist direct patient care services are provided upon attending physician request (e.g. clinical pathology consultations); or in association with the services of the attending physician or surgeon (e.g. surgical pathology); or upon identification by the pathologist that a laboratory service requires his or her direct involvement (e.g. cytopathology, hematology, blood bank services).

Hospital economic incentives under the DRG payment system should not be allowed to directly influence when, whether or to what extent pathology services are provided to individual patients. The role of the hospital as "gatekeeper" for hospital-based physician services during the patients' stay in the hospital is inappropriate. Hospitals are not qualified to make critical medical decisions that directly affect the immediate diagnosis and treatment of the individual patient.

4. Any payment modification which bases payment for hospital-based physician services on DRGs and makes payment through the hospital raises grave concerns. All of the economic incentives would be directed toward under-provision of care. This jeopardizes the role of the physician as an advocate for the patient.

Payment to the hospital through the DRG rate would provide no assurance that hospitals would use the payment to provide hospital-based physician services to patients. With the inception of the hospital prospective payment system, some pathologists have not been paid for Medicare Part A services by the hospital even though Part A payment for their services is included in the DRG rate. Inclusion of payment for Part B services of hospital-based physicians in the DRG rate would further compound this problem.

5. There is no objective evidence which provides adequate guidance on the technical feasibility of determining the "right" amount to pay for hospital-based physician services through the DRG payment to hospitals. Operational considerations have not been addressed nor have the implications for possible adverse effects on patient care been analyzed.

6. The HCFA financed Harvard relative value study will be demonstrating methods for determining the relative value of pathology services to individual patients. A special panel is now being formed so that this important work can begin. The College believes this approach has merit and should proceed without the intervention of a drastic change in the present system for payment of Part B pathology services.

Conclusion

The College of American Pathologists appreciates the opportunity of sharing with the Committee its views on alternative payment methods for Part B physician services. The College supports appropriate efforts to improve the fee-for-service system. In this regard we are sincerely appreciative of recent action the Committee has taken in working with the College to address some of the inequities of the current system of payment for pathology services.

The College strongly urges Congress not to legislate abrupt changes in payment method for hospital-based physician services which appear to us to be conceptually flawed and technically unfeasible. Payment of a DRG-related amount for pathology Part B services would be extremely disruptive and would not accomplish the goal of quality care at reasonable prices. The College supports the relative value study for physician services because this approach holds greater potential for assuring payment system modifications that will achieve the dual goals of consistently high quality services for a reasonable price.

TESTIMONY OF DONALD C. HARRINGTON, M.D.
IN A RESPONSE TO A REQUEST FROM
COMMITTEE ON FINANCE, UNITED STATES SENATE

Subject: Proposals to Modify Medicare's Physician Payment System

The use of DRGs for prospective hospital payment has produced a mass migration of services to non-DRG controlled places of service, i.e., x-ray, lab, and ambulatory surgery, to name a few. Most health claims processors are not experienced in ambulatory review and need assistance. I would like to offer the "Patterns of Treatment", which I have catalogued, as a basis for physician payments and a method to reduce overutilization, "procedure creep", and underutilization of ambulatory health care services.

Three ingredients are needed in a physician payment system to assure quality of care and cost containment: (1) a fee schedule ("Patterns of Treatment" is not involved here; it merely accepts the schedule developed by the responsible organization); (2) Patterns of Treatment (or equal process) to assure control of overutilization and procedural creep (for a percentage of our doctors, a mere fee schedule is a license to steal unless supervised) or underutilization to assure quality; and (3) retrospective review to monitor the "Patterns of Treatment" and to identify providers using procedure numbers incorrectly.

"Patterns of Treatment" regulates the ambulatory health care conditions that utilize the same physician services, laboratory procedures, x-ray examinations, and ambulatory surgery for a specific ICD-9 classification. Each "Pattern" lists physician services as to the comprehensiveness of the service needed, i.e., Established Patient Office Visit, 90040 (brief) vs 90050 (limited), or 90060 (intermediate); and as to the frequency required for the diagnosis involved, i.e., one per month, two per quarter, six per year. Laboratory and x-ray services are similarly listed as to the usually allowed procedure and as to the frequency recommended. Ambulatory surgical procedures are not categorized by frequency but are listed as those needing prior authorization or second opinions.

As a result of extensive experiences in medical utilization review and from this obvious need to control ambulatory services, it was decided to update and computerize an earlier work. Discussions were held with the Senate Subcommittee on Health, House Ways and Means Committee, and several meetings with representatives of HCFA. Following these meetings, further discussions were held with the leadership of the various professional colleges and academies (ACP, ACOG, AAFP, etc.), consultative meetings were then developed and carried out for each of the "Patterns". The members of those consultative meetings consisted, as a rule, of the following physicians: two from the medical organization relating to the "Pattern"; two from the surgical; one from Family Practice, and two review physicians from an HMO/IPA, PPO, or Foundation for Medical Care.

Prior to and during these meetings, the diagnoses codes were adjusted to ICD-9-CM June 1985; the procedure codes to CRVS 1974 and CPT 1984. The listed procedures and times done were aligned with 1985-86 practice patterns. Twelve meetings held in 1985-86 in various parts of the country were attended by 67 physicians representing the disciplines involved in the "Patterns".

Quality assurance under "Patterns of Treatment" takes two forms: (1) Underutilization: Here, all diagnoses that are suspected of concealing a more serious diagnosis are remanded for review if certain laboratory, x-ray or surgical procedures are not done in a specified length of time, i.e., if intermenstrual bleeding is noted on claim forms for over three months, some form of intrauterine endometrial sampling must be done or the computer remands the claim for medical review; (2) Outcome analysis: All serious diagnoses that may have been preceded by a deficit in medical care of patient disregard are remanded for medical review along with the patient's profile for study of the total care received by the patient. Examples: Hospitalization for diabetic coma; ruptured appendix; Stage IV Carcinoma of Cervix; and many others.

"Patterns" will reduce costs by as much as 40%. Several large claims-paying organizations are programming the "Patterns" at the present time. Testing the updated computerized "Patterns" against previously paid claims history shows extremely meaningful program savings.

During the development of the "Patterns", we realized the need to continue yearly updating by qualified medical experts. We also realized the need to protect the accuracy and quality of the "Patterns". To this end, a small corporation was developed with Donald C. Harrington, M.D., FACS-FACOG, one of the original developers of ambulatory review, Robert B. Talley, M.D., FACP, also involved early on and to the present with ambulatory review; Boyd Thompson, Past Executive Vice President of American Medical Care and Review Association; and the American Medical Care and Review Association as the primary founders. The organization, Concurrent Review Technology, Inc. has only one function: to produce, update, distribute, and protect the accuracy of the "Patterns of Treatment".

MGMA
Medical Group Management Association Founded 1926
Executive Office

STATEMENT OF THE MEDICAL GROUP MANAGEMENT ASSOCIATION

TO

THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE
UNITED STATES SENATE

MEDICARE'S PHYSICIAN PAYMENT SYSTEM

APRIL 25, 1986

Contacts
Cynthia B. Trainor, PhD
MGMA Government Relations Director
(303)753-1111

and

Robert J. Saner, II, Esq.
MGMA Washington Legal Counsel
(202)659-2900

1355 S. Colorado Blvd., Suite 900 Denver, CO 80222 (303) 753-1111
Affiliated Organizations: American College of Medical Group Administrators,
Center for Research in Ambulatory Health Care Administration

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The Medical Group Management Association (MGMA) appreciates the opportunity to present these views for consideration by the Senate Finance Committee as it reviews Medicare payment for physician services. MGMA is the oldest and largest professional association of group practices, representing over 2,900 medical groups in which approximately 65,000 physicians practice their profession. MGMA member groups represent the broad spectrum of medical organizations in the United States, including large multi-specialty clinics that draw patients in need of sophisticated tertiary care from throughout the world to small single-specialty group practices serving a local medical market. Some member groups still operate exclusively on a fee-for-service basis, others are entirely prepaid, and many combine both aspects. Many are still free-standing clinics, while a growing number are affiliated with hospitals, medical schools, or health maintenance organizations, and in some cases all three. A few own their own hospitals and/or health maintenance organizations and serve as the centerpieces of emerging integrated health systems.

In addition to its 2,900 group members, MGMA represents over 6,000 individual healthcare administrators. These are the individuals who must implement changes in Medicare payment policy as that policy evolves through legislative and agency action. As part of its educational services, MGMA has worked closely with HCFA to ensure that the significant changes to Medicare already legislated through the Tax Equity and Fiscal Responsibility Act of 1982, the Social Security Amendments of 1983, the Deficit Reduction Act of 1984, and now the Consolidated Omnibus Budget Reconciliation Act of 1985 are understandable to, and implemented by, physicians throughout the country.

Criteria for Reform

As the Committee reviews various alternative changes to the Part B payment mechanism, our organization would encourage Committee members to consider several important but relatively simple criteria.

First, the system should remain pluralistic. Most of the payment alternatives under consideration have some demonstrable merit in some circumstances. However, no single option has been tested and proven obviously superior to current methodologies. Therefore, any significant reforms undertaken at this time should expand the range of options available to both physicians and patients, not limit them.

Second, if the participating physician concept is to remain in Medicare, it should continue to be voluntary. Mandatory assignment either under the current system, or any of the other systems under consideration, will ultimately reduce the quality and availability of services to beneficiaries. Federal policy should not be based upon erroneous assumptions about the economic status of the elderly. Recent studies demonstrate that a significant portion of the Medicare beneficiary population is capable of paying for medical services when they choose to do so.

Third, in reviewing possible Part B changes, this Committee should insist that the Congress go back to debating healthcare on the basis of policy and not just on the basis of budget. Too many of the Medicare reforms of the past five years have been motivated solely by budget considerations and may risk undermining major reforms, such as the prospective payment system and TEFRA risk-contracting initiatives, which were policy-based.

Fourth, and this factor is of particular importance to MGMA's membership, any significant changes to Part B should be undertaken with adequate lead time for careful design and subsequent implementation. The Medicare payment system has already absorbed an enormous number of changes in the last five years, leading to vastly increased complexity. To understand the payment rules is becoming comparable to trying to understand the tax code. If such complexity is necessary, those who have to implement change must be given adequate time to do so.

Longer-Term Reform

A number of structural reforms in Part B, including MD-DRGs, fee schedules, vouchers, and other capitated payment arrangements have been under discussion in the Congress, the Health Care Financing Administration (HCFA), and in both the research and medical communities. The Medical Group Management Association does not currently favor one of these proposals to the exclusion of the others, but believes that all merit further study. Some, if they are to be seriously considered, will require more detailed demonstrations than have yet been undertaken, particularly the voucher and capitation options.

A significant number of MGMA members view capitation as a viable and promising alternative for physician payment, but there are a variety of ways it could be undertaken. The Administration's voucher proposal focuses primarily on the use of financial intermediaries and/or employers. MGMA believes that an equally promising alternative would be direct capitation through medical group practices serving Medicare beneficiaries within their service areas. MGMA's Center for Research in Ambulatory Health Care Administration has combined its resources with Mathematica Policy Research, which has submitted to HCFA a proposal to further refine and demonstrate this option. That proposed program would conduct a real world demonstration of this concept at 25 to 30 group practice sites throughout the country. Based on initial inquiries, a substantial number of medical group practices have both the capability and interest to participate in such a demonstration.

MGMA urges the Committee to explore carefully the role group practices can play in any new payment system and not assume that some financial intermediary or other health system configuration needs to be interposed between the Medicare program and practicing physicians. Most financial intermediary arrangements will by their nature add another administrative cost layer which diverts dollars away from direct patient care. The MD/DRG concept has particular problems in this regard. While use of a hospital's medical staff as a payment unit may be feasible in some circumstances, in many others it would be an artificial construct at cross purposes with mainstream developments in the organization and management of medical practice.

Shorter-Term Issues

1. Fee Freeze/Medicare Economic Index. MGMA urges the Committee to let the remaining aspects of the Part B physician fee freeze expire at the end of 1986 under the terms of the recently enacted COBRA legislation. As MGMA has communicated to this Committee previously, the freeze was inequitable at the outset, since all sectors of the economy were not frozen, and those inequities have simply been compounded by its extension. For the same reason, the Congress should prohibit the Administration from imposing retroactively its revised Medicare economic index, which would effectively produce no increase in prevailing charges. As Senator Durenberger stated on April 24, the 0.8 percent increase in the fee screen "is tantamount to an extension of the fee freeze for a third year." If there is a technical deficiency in the current index, it can be corrected with prospective effect, rather than retroactively asking physicians to make up for 13 years of payment errors.

2. Inherent Reasonableness. MGMA is concerned that the Administration's announced program of "repricing" physicians' services may be the wrong way to achieve budget savings. While some improvements in the current "CPR" methodology are certainly warranted in limited situations, HCFA has asserted blanket authority to

virtually reverse twenty years of Medicare law and policy with respect to the pricing of physician services. MGMA appreciates the leadership which Senators Dole, Durenberger, and Bentsen have taken on this issue with the introduction of S. 2368. We think it important that the Congress, not HCFA, set out the factors which would justify the repricing of existing services, and ensure that the change in reasonable charges or charge methodology for each particular service be done through _Federal Register_ rulemaking with review and comment. MGMA would encourage the Committee to take one additional step not now provided in S. 2368 as introduced, and make these rulemakings subject to judicial review under Administrative Procedure Act standards. One of the great inequities in Part B of the Medicare program has been the ability of HCFA to act in an arbitrary and capricious manner knowing that its actions were insulated from legal process.

3. _Clinical Laboratory Issues_. The Administration also proposes to freeze payment for clinical laboratory services for one year. Laboratory work has been the chopping block for budget cutters in recent years, and the fees paid by Medicare have already been severely curtailed, first by the Deficit Reduction Act and subsequently by COBRA. In addition to limiting what Medicare will pay, COBRA has extended mandatory assignment to physician office laboratories, an action which should be promptly reversed. This action was taken without the benefit of hearings in either House, and

was added in conference without having been included in either the House or Senate bill. Physicians deserve more consideration than that on an item as important as mandatory assignment. Physician office laboratories have important benefits for patients with respect to enhancing integrated care, patient access to lab services, and prompt turn-around time, particularly in rural areas. These beneficial aspects of physician office labs may positively impact on the quality of care and may produce savings for patients. Physicians with office laboratories should not be discouraged by arbitrary reductions and/or payment freezes.

4. HMOs and Competitive Medical Plans. The Administration has proposed a voluntary voucher, and as discussed above, it should be explored further. In the short-run, however, the Administration could do more to expand the use of the TEFRA risk contracting mechanism which has already proven popular with Medicare beneficiaries and providers. There are certain technical impediments in the current program which serve to prevent capable group practices from serving as competitive medical plans. For example, in areas of intense HMO competition for non-Medicare patients, the "50/50" rule, which requires that no more than 50 percent of an HMO's/CMP's enrollment be comprised of Medicare and/or Medicaid enrollees (42 CFR, Part 417.413), prevents viable, well established medical groups with a long history of serving Medicare beneficiaries from

offering their current patients, as well as prospective ones, the prepaid option. Instead, patients who have been treated at a group practice on a fee-for-service basis are forced to enroll in someone else's HMO, which then contracts back with the medical group for the provision of services. The same patient sees the same physician in the same setting, and an unnecessary layer of administrative expense has been interposed in the system. MGMA is working with HCFA to see if technical problems of this nature can be resolved without legislation and would appreciate the Committee's support in this area if legislation is ultimately necessary.

5. Direct and Indirect Medical Education Expenses. The Administration has proposed further changes in compensation for medical education. Again, they are motivated by a desire for budget savings and are unrelated to policy. The changes incorporated in the recent COBRA legislation for revising Medicare payment for both direct and indirect medical education should not be carried further. Faculty practice plans at teaching institutions throughout the country are a significant and distinct part of the group practice community and contribute their resources to serving medically indigent and inner-city populations in many areas. These groups will be adversely affected by the Part A reforms already enacted and should not be buffeted by the further changes the Administration has suggested for implementation in FY 1987.

6. Stand-by Anesthesia and Assistants at Surgery. Just as HCFA should not have carte blanche authority to reprice physician charge levels, similarly, it should not have unfettered regulatory discretion to determine that medical services long recognized as medically necessary are suddenly superfluous. This Committee should exercise vigilant oversight of any regulatory initiatives to prospectively and arbitrarily deny payment for stand-by anesthesia or to add other surgical procedures to the list already identified by Congress.

Conclusion

The Medical Group Management Association appreciates this opportunity to comment on prospective changes to the Medicare Part B physician services program. MGMA urges the Senate Finance Committee to proceed deliberately so as to ensure that any further changes preserve Medicare's commitment to high quality care for beneficiaries provided by the physician or delivery system of their choice. The Association would be pleased to work with the Committee Members and staff to ensure this result.

A DEMONSTRATION AND EVALUATION OF DIRECT PHYSICIAN CAPITATION UNDER THE MEDICARE PROGRAM

A Proposal to HCFA

Submitted by:

Mathematica Policy Research, Inc.

and

Medical Group Management Association

Objectives

Mathematica Policy Research and Medical Group Management Association propose to design, implement, and evaluate a demonstration of direct capitation to medical groups for services provided to Medicare beneficiaries who agree to participate in the program. The critical questions to be addressed through this demonstration include:

1. Is direct capitation to medical groups feasible? Can and will medical groups assume financial risk? Can necessary reporting and monitoring procedures be developed and implemented?
2. What is the nature and extent of biased selection into the demonstration?
3. What is the impact of the demonstration on use and costs of services by Medicare beneficiaries, after biased selection is accounted for?

The answer to these questions will permit HCFA to determine whether a policy to directly capitate medical groups is feasible and desirable. If so, the potential benefits of capitation may be achieved more rapidly than is possible under current regulations which restrict capitation payments to qualified HMOs and CMPs.

Summary

Under this project, a demonstration of direct physician capitation under the Medicare program will be designed and implemented. The key elements of this demonstration will include:

- Up to 20 geographically representative medical group practices will be recruited to participate in the demonstration.
- These medical groups will enroll Medicare beneficiaries into the capitated project.
- For each Medicare beneficiary enrolled, the medical group will receive 95% of the Part B AAPCC.
- A hospital pool, set at 95% of the Part A AAPCC, will be established and the medical group and HCFA will share equally any surpluses generated annually during the demonstration.
- The demonstration will be conducted for two full years in order to obtain sufficient information and data to evaluate the feasibility and impact of the program.

Evaluation of the demonstration will focus on three critical issues:

- Feasibility: Case studies will be conducted on the implementation and operational experiences of the medical groups accepting capitation for Medicare beneficiaries. These case studies will particularly examine problems which arose and the mechanisms developed to address these problems.
- Biased selection: The prior use, health status, and attitudes toward health care of capitated beneficiaries will be compared with those of comparable beneficiaries in the same markets, in order to determine whether these beneficiaries are atypical for their AAPCC category and, in turn, whether medical groups may be over or underpaid for services to be provided to these beneficiaries.
- Use and cost of services: If direct capitation to medical groups results in cost savings, it will be important that HCFA know the source of these savings (e.g. reduced use of specific services or all services, greater efficiency, ability of the group to negotiate discounts).

Mathematica Policy Research, Inc. and the Medical Group Management Associaton will jointly design and conduct the demonstration and evaluation. MGMA, which represents the majority of medical group practices in the U.S., will assist in recruiting medical groups and negotiating agreements, provide technical assistance to participating medical groups, and provide liaison between the medical groups and the evaluation.

Mathematica Policy Research has conducted a large number of major health demonstrations and evaluations for the government. It will design the demonstration and evaluation and will evaluate the feasibility and impacts of direct physician capitation under the Medicare program.

Testimony Prepared for Submission for the Record of the Hearing by the Health Subcommittee, Senate Finance Committee on Proposals to Modify the Medicare Physician Payment System

by Craig E. Polhemus, Associate Director & Counsel
New York State Office for the Aging
April 25, 1986, SD-215 Dirksen Senate Office Building, 9:30 a.m.

Chairman Durenberger and Subcommittee Members:

I thank you for the opportunity to submit this testimony for the record, and for your interest and commitment to health care for older and disabled Americans.

Today's hearing on proposals to change Medicare's physician reimbursement system is part of a continuing congressional commitment both to quality health care for Americans in need and for fiscal prudence in developing an efficient and effective health care financing system.

Too often, Congress considers only short-term legislative proposals designed to deal with an immediate crisis -- such as intolerable deficits. On those occasions, advocates for the elderly can do little except dissent: "No, do not increase the financial burden on elderly citizens who already face excessive health care costs." "No, do not cut back covered services."

In truth, however, elderly Medicare recipients suffer even more from escalating health care costs than do the Medicare trust funds. And so, on behalf of more than two million New Yorkers over the age of 65, I can fervently agree with those seeking to contain Medicare expenditures that, yes, the current system is intolerable.

Last year, we celebrated the anniversaries of two vital government programs serving older Americans. One such anniversary celebrated the most successful public program of all time: the fiftieth birthday of Social Security. The other anniversary was the birthday of an utter failure: the twentieth birthday of Medicare.

Today, Social Security covers virtually every American and pays benefits to more than seventy million people each year. Moreover, the retirement trust fund now runs a surplus projected to reach $204 billion by 1990. The Social Security system is strong, reliable, and successful in providing at least a measure of protection against impoverishment, disability, ill health, and unemployment.

Medicare's intent is a noble part of the Social Security Act. Last year, Governor Mario Cuomo (responding to a resolution sponsored by Senator Daniel Patrick Moynihan, New York's senior Senator, who serves on this Senate Finance Committee) declared 1985 to be "The Year of Social Security" in New York State. In doing so, he did not focus just on retirement benefits, for the Social Security Act is much more than that. The Save Our Security (SOS) Coalition emphasizes the unity of these interlocking programs for so many groups of Americans in need when it declares:

"We believe in the whole law. . . . All twenty titles of the Social Security Act need to be preserved and strengthened."

The weakest title of the Social Security Act, that most in need of strengthening, is Title XVIII. Medicare, which was designed to shield the elderly from spending so high a percentage of their income on health care, has completely failed to meet this goal: Today, older Americans spend a greater share of income on health care than before the enactment of Medicare.

(An ironic twist on this development is David Stockman's proposal to count Medicare benefits as income. By the philosophy of the former Office of Management and Budget Director, an elderly person who is sick enough to have thousands of dollars worth of medical bills paid by Medicare or Medicaid is somehow less poor than a healthy person with the same personal income.)

Even worse, and unlike Social Security, Medicare is not fiscally sound in its current form. And it does not protect older people from excessive, and rising, health care costs. It is a costly failure.

As the House Select Committee on Aging has documented, personal health care expenditures consumed 12.3% of mean income for those aged 65 and older in 1977, rising to 14.5% in 1984. By 1989, even without further Medicare cutbacks, older Americans will be forced to spend an average of 18.4% of their income on health care.

Do these statistics reflect an overly generous program, one providing too much protection to the elderly? Only if you agree with the Red Queen in Through the Looking Glass, who said, "Now, here, you see, it takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!"

Twin problems face the Medicare system today:

--The pending financing crisis, which is projected to produce deficits of up to $300 billion by the end of this century unless revenue or expenditure changes are made; and

--The system's increasing inability to protect the elderly and disabled against rising health care costs.

Both these problems must be addressed in ways that will assure equal access to health care for all Americans, rich or poor. Both must be approached with compassion and concern for those among us most in need of health care and least able to pay for it. The appropriate role of government in health care -- as in dealing with the homeless, the unemployed, the hungry -- is to help those most in need, those least able to bear the burden alone.

These gaps in Medicare have been present from the beginning. Although 80% of older Americans believe they have long-term-care health insurance either through Medicare or Medigap policies, the truth is that long-term-care services are covered by neither system, but only by Medicaid. Preventive services are generally excluded from Medicare, as are out-of-hospital prescription drugs.

These flaws in the Medicare program have contributed, over the years, to the diminished protection provided elderly participants. So any changes in the reimbursement provisions of Medicare must be designed to enhance the program's effectiveness, not to harm it.

Some physician reimbursement changes that the Administration has implemented are improovements to Medicare. For example, regulations have been promulgated to permit Health Maintenance Organizations to enroll Medicare patients.

Other reimbursement changes have been harmful. The restrictive reimbursement guidelines of the Social/Health Maintenance Organization demonstrations (S/HMO's) have virtually ruled out effective program operations within allowable resources. The non-renewal of National Long-Term Care Channelling Demonstrations, including one in Rensselaer Coutny, New York, which was coordinated by the New York State Office for the Aging, raises doubts about Federal interest in implementing successful and cost-efficient health care delivery mechanisms.

Yes, let us pay physicians more appropriately for needed health care for the elderly and disabled. Let us stop encouraging physicians to order ten tests rather than spending ten minutes talking with the patient about her health problems. Let us start meeting the real health care needs of the elderly -- which include preventive and chronic-care therapy, as well as acute treatment.

I am appalled that the nominee to run the Health Care Financing Administration, Dr. William Roper, has been quoted as saying that a two-tier medical system is inevitable: one for those who can afford to pay their own bills and another for those dependent on government programs. As the Study Group on Social Security has pointed out, "[T]his is the very class system Medicare was designed to prevent." In 1965, this Congress agreed with President Johnson that elderly Americans deserved equal access with younger people to quality health care at a cost they could afford.

It is especially ironic that cutbacks in Medicare are considered now, amid headlines claiming that generations are in conflict. Back in January, the Albany Times Union ran a feature headed "Robbing from the cradle: America's elderly putting the squeeze on future generations". Then there was Silvia Porter's column headlined, "Young U.S. workers don't grasp worth of Social Security". The National Journal proclaimed that "The Older Generation's Nest Eggs Have Grown". Using the same statistics, the Washington Post concluded, "Many Elderly Can Afford Luxuries, Study Says". A New York Times reporter, in her lead, wrote that "Four years after the Reagan Administration began reducing spending for social services, a group of analysts for the Urban Institute has concluded that the retrenchment has generally spared the elderly but has seriously hurt programs for children, young adults, and the long-term unemployed."

Certainly there appears to be conflict -- at least in the headlines. Media attention can be a type of self-suffilling prophecy, however -- at least one group, calling itself "Americans for Generational Equity", has tried to help stir up a "Children's Crusade" against their grandparents. Now, who can be against "generational equity"? Not I -- but I strongly protest the use of "equity" to describe proposed cutbacks in programs for our elderly citizens. "Americans for Generational Equity" was organized in December 1984. George Orwell's language called "Newspeak", from his novel 1984, seems to have arrived right on time.

What are the facts behind this media hype? Are our elderly "putting the squeeze" on younger Americans, as the Times Union put it?

The truth is that, thanks to Franklin D. Roosevelt, older people have benefited from the most successful social program ever designed -- Social Security. And thanks to Social Security, together with the Supplemental Security Income program begun in 1972, the poverty rate for Americans over 65 dropped dramatically, from 55% in 1959 to 14.1% in 1983 until finally, around 1982, it edged below the poverty rate for the general population.

Even then, the 1982 "jump" in the relative position of the elderly did not represent more generous benefits. No, the major reason was that there was a great deal of unemployment in 1982, so that more working-age people found themselves out of a job and sliding into poverty. Comparatively more older people, combining Social Security with savings and private pensions, had incomes just above the poverty line.

Not that much above poverty, though. Twenty-nine percent of Americans over 65 are below one and half times the poverty level -- a higher rate than for nonelderly Americans. Meanwhile, the financial costs of long term health care has skyrocketed -- virtually no one, today, can afford more than a year or so of nursing home costs before spending down to Medicaid, all too often impoverishing the spouse left behind in the community as well. More than 80 percent of the elderly suffer from at least one chronic, often debilitating disease such as arthritis, heart conditions, or diabetes and multiple conditions. And year by year, both Medicare and Medicaid are cut deeper and deeper.

Is the New York Times right -- have recent cutbacks "spared" the elderly? Those readers who delved past the lead paragraph found that the Urban Institute, in this study, took Dave Stockman's idea even further. Their conclusion that, while domestic cutbacks financed our burst in defense spending and skyrocketing deficits financed a tax cut, the elderly were somehow "spared" from the sacrifices was based on the continued growth in Medicare spending. Yet in those same years, Medicare coverage was reduced, premiums increased, and copayments expanded. The Urban Institute apparently feels that it's not just, "The sicker you are, the richer you are", but even "The more your doctor charges Medicare, the richer you are".

Today, twenty years after Medicare's enactment, elderly people are spending a greater percentage of their income on health care than before it was passed. Older Americans on Medicare should receive a card from the Federal Government saying, "You have our condolences. A donation has been made in your name to the American Medical Association."

So if Medicare is the grievance, older and younger Americans should not be fighting each other -- we should be joining hands to create a universal national health care financing system that helps us maintain good health and obtain quality health care without breaking the bank.

When Governor Cuomo took office in New York State, he issued a report prepared by an interagency task force on "Medicare: Analysis and Recommendations". As endorsed by that report, I strongly urge that any Medicare changes considered address their effects on State and local governments. President Reagan's budget proposal for Federal Fiscal Year 1987 included changes that would result in over $50 billion in cuts in health care programs over the next five years. Under the Medicaid "cap", New York State and local governments would lose $400 million in FY 87 alone. These proposals would result in an arbitrary reduction in Federal fiscal responsibility for Medicaid without addressing the fundamental problem of health care cost containment.

I urge this Committee to focus once again on the goal of Medicare: providing quality health care to meet the needs of American's elderly at an affordable cost and within a cost-efficient system. Structure payment systems to encourage medical care meeting the unmet health care needs of the elderly and disabled, and expand Medicare's inclusion of capitation, preventive, and long term care needs, with support for effective State health cost control initiatives. Medicare need not remain a costly failure. I wish you great success as you seek changes to help it succeed.

Testimony of

THE OUTPATIENT OPHTHALMIC SURGERY SOCIETY

Physician Reimbursement Reform:
Administration's FY 1987 Budget
and
"The Medicare Physician Payment Reform Act of 1986" (S.2363)

Presented Before

Senate Finance Subcommittee on Health
The Honorable David Durenberger, Chairman
Friday, May 2, 1986

The Outpatient Ophthalmic Surgery Society is a professional medical specialty organization of over 1,000 ophthalmic surgeons dedicated to the conduct of safe, effective, and cost-effective surgery in the various outpatient surgical environments -- ambulatory surgical center, office-based surgical suite, and hospital outpatient department. It is a privilege to present our comments on the issue of physician reimbursement reform under the Medicare program.

As ophthalmic surgeons, it is imperative that we work in partnership with federal policy-makers to revise the Medicare physician payment system in a manner which will contain costs without reducing benefits and without compromising the quality of care afforded Medicare beneficiaries. We acknowledge that Medicare is a principle payor for ophthalmic services, particularly cataract surgery, and that the government's share of these costs will increase in the decade ahead as more and more beneficiaries avail themselves of this remarkable surgical technology which restores vision to cataract patients.

However, we object to the Administration's effort to implement piecemeal cutbacks, directed at the ophthlamology community, through agency action, rather than to develop fair and rational statutory reform. The Administration's budget effectively short-circuits a number of the initiatives currently underway to promote the establishment of comprehensive reform: the long overdue government report to

Congress on physician payment reform; the Harvard University project exploring the feasibility of a relative value scale for physicians; and, the Physician Payment Review Commission, established by "The Consolidated Omnibus Budget Reconciliation Act" (COBRA).

The Reagan Administration's FY 1987 budget proposal includes provisions for significant reductions in payments for physician services. Among these are proposals for the correction of the housing component of the medical economic index, retroactive to 1974; the reduction of payments for "procedures that are overpriced because of technological or productivity advances or geographic variations"; elimination of, or reductions in, payments for "standby" local anesthesia services; and the imposition of coinsurance requirements on the facility fees paid to Medicare-certified ambulatory surgical centers. We strenuously object to these proposals and recommend that Congress take appropriate action to block their implementation and address the issue of physician reimbursement reform in a cogent, comprehensive, and equitable fashion. We believe that "The Medicare Physician Payment Reform Act of 1986," introduced by Senators Durenberger, Dole, and Bentsen, represents a more reasoned, although not entirely acceptable, piecemeal, alternative to the Administration's proposals.

Reductions in Professional Fees Paid for Targeted Procedures

HCFA intends to reduce professional fees for cataract extraction, cardiac pacemaker implantation, and coronary bypass surgery by at least $100 million in FY 1987. In order to attain these savings, HCFA has proposed a regulation which would authorize the agency to establish special reasonable charge payment limits for certain services identified by the agency as "overpriced." The agency's proposed regulation was published in the Federal Register on February 18, 1986 (51 Fed. Reg. 5726). These regulations cite existing statutory authority as the basis for the agency's efforts to set national limits on specific physician services. In essence, the proposal purports to authorize the agency to determine the need for limits based upon factors which are not indentified or explained and establish these limits based upon information which is not subject to verification.

We object to this proposal for the following reasons:

° The preamble to the proposed "inherent reasonableness" rules cites existing statutory language as the basis for HCFA's efforts to set national limits on cataract procedures, among others. In fact, there is no apparent authority for HCFA's establishing national limits on reimbursement for specified physician services.

° Under the President's FY 1987 budget proposal, cataract surgery, as well as several other procedures, would be selectively targeted to bear the brunt of budgetary cutbacks. The selection of these procedures appears to be based as much on the fact that they constitute a significant percentage of the surgical procedures performed for Medicare beneficiaries as on evidence that these procedures are "overpriced" as compared to other procedures of comparable complexity.

° A determination that a particular procedure is "overpriced" can only be made in the context of an examination of the relative complexity and resource-intensity of other procedures. The piecemeal approach adopted by the Administration is inconsistent with the development of a rational, equitable methodology for weighing the relative value of all procedures. Any effort to reform payment for physician services should be comprehensive and should be undertaken only if Congress has adopted legislation directing HCFA to implement a revised payment methodology.

° Focus on cataract procedures apparently stems from a perception that advances in technology have rendered the procedure less difficult and less time-consuming, and that it is the technology, rather than the surgeon, performing the surgical procedure. Both of these assumptions are incorrect. Advances in technology have improved the results of cataract surgery and have reduced complications. Yet, the procedure is far more difficult and complex, and requires a greater skill, than the procedure administered a half-decade ago. Moreover, the time required to perform cataract surgery now is no less than it was five years ago. Notwithstanding this fact, it is inappropriate to utilize incision time as a barometer for payment rates, as HCFA apparently intends to do. The remarkable success of cataract surgery today is a result of an expanded personal effort by the surgeon and involves extreme care in incision, removal of tissue, irrigation of the eye, and implantation of the IOL.

S.2363 represents an improvement on the Administration's approach, but remains flawed in its provisions enabling the Department of Health and Human Services to target certain procedures for an increase or decrease in payment based upon the "inherent reasonableness" of fees. As stated above, we believe that this piecemeal orientation to reform will only exacerbate the inequities of the existing system, and we respectfully recommend that the Committee direct the Department to develop a comprehensive, equitable, and systemic reform to the physician reimbursement system, rather than target high-utilization procedures for arbitrary reimbursement reductions.

However, the sponsors of the legislation are to be commended for requiring that HCFA moved forward with such an initiative with some semblance of due process. The legislation would establish a number of factors which the Secretary must consider in determing the appropriateness of applying "inherent reasonableness" limitations. The bill would also require that HCFA provide at least sixty days' notice of changes in payment methodology or rates. We also share the sponsors' concern that any reimbursement limitations reflect regional variations in fees and that single national payment rates not be established for targeted procedures.

Finally, we support that section of the proposed legislation which would require that the Physician Payment Review Commission comment on all such physician reimbursement limitations and reforms prior to their ultimate promulgation.

Standby Anesthesia Reimbursement

HCFA is also proposing to limit payments to physicians for "standby" anesthesia services. Cutbacks are being considered where the anesthesiologist does not administer general anesthesia and/or is supervising concurrent operations. The imposition of limits on the use of anesthesiologists in cataract surgery would represent an unprecedented intrusion of government into the practice of medicine, since most cataract surgeons view the presence of an anesthesiologist during cataract surgery as essential to the health and well-being of the patient.

The Administration's proposal can only have the effect of inhibiting the access of beneficiaries to needed services. The cataract patient is of an age "here existing medical conditions like diabetes, atherosclerosis, cardiovascular disease, and high blood pressure can provoke a medical emergency during surgery. The availability of effective anesthesia personnel is essential, since the surgeon and his personnel must devote all their attention to the operative eye.

The Administration's proposal seems to be imbued with the misconception that when the anesthesiologist is not providing the anesthetic block, he or she is somehow rendering a lesser service. Yet, in these circumstances, the ophthalmologist is relying on the anesthesiologist to monitor the patient's vital signs and level of anesthesia, provide intravenous medication, and to provide oxygen or other services necessary to alleviate pain and anxiety, as well as to resuscitate the patient in distress during surgery. As required under TEFRA regulations, the anesthesiologist, with respect to the outpatient, performs a pre-anesthesia examination and evaluation; participates in developing the anesthesia plan; monitors the course of anesthesia; remains physically present and available for immediate diagnosis and intervention during emergencies; and providers post-anesthesia care.

The Outpatient Ophthalmic Surgery Society believes that it is imperative that Medicare continue to separately reimburse for anesthesia services associated with cataract surgery. Proposal to eliminate or reduce payments for "standby" anesthesia services embody a significant risk to the health and well being of the more than one million elderly people undergoing cataract surgery each year.

Retroactive Adjustment of Medical Economic Index

OOSS objects to the Administration's proposal to retroactively correct the medical economic index (MEI) as applied to physician payments. Applying this change retroactively clearly imposes an unfair burden on physicians who have relied upon HCFA's prior methodology. Moreover, as articulated by the American Medical Association in its testimony before the Committee, the MEI has not provided a "windfall" for physicians. It has not served as an accurate measure of inflation over the period from 1976 to the present, and has failed to accommodate cost increases in medical care as gauged by the rate of increase in the medical care component of the CPI. In essence, the Administration is proposing to reformulate an already inaccurate index in a manner which makes its application all the more inequitable.

The impact of retroactive application of this change is particularly harsh for ophthalmic surgeons who perform surgical services in ambulatory surgical centers and surgical suites established adjacent to their private offices. HCFA has never implemented the program for reimbursement of office-based surgery enacted by Congress in §934 of the Omnibus Budget Reconciliation Act of 1980, and, as a result, physicians performing surgical services in their offices have had to subsidize the facility costs of their surgical practices through professional fees which have been frozen for two years.

Moreover, Medicare has never updated the facility payment rates paid to ASCs, and the payment rate for cataract surgery (approximately $504) is approximately $100 to $300 less than the actual cost of performing these services in ASCs. Hence, physicians who are performing surgery in ASCs are likewise subsidizing their facilities with their surgery fees. The physician fee freeze has proven to be a significant disincentive to the establishment of these lower-cost, high quality physican-sponsored facilities. The retroactive application of the adjustment to the medical economic index will continue to inhibit the movement of surgical procedures from institutional settings to less costly ambulatory environments.

Although S.2363 represents an improvement over the Administration's proposal in that it would phase in the modification over a two-year period, we believe that any retroactive application is inequitable and counter-productive to the government's goal of promoting the conduct of surgery in ASCs.

Coinsurance Requirements for ASCs

The President's FY 1987 budget proposal also proposes to impose beneficiary coinsurance requirements on "facility" costs incurred by ambulatory surgical centers. In the case of cataract procedures, this would amount to a coinsurance requirement of approximately $100 for the procedure under the current facility rate of about $504. Similar coinsurance amounts would be imposed for the conduct of approximately one hundred other procedures which can be reimbursed when performed in an ASC.

It is well established that ambulatory surgical centers are paid considerably less for surgical procedures than hospital outpatient departments -- indeed, according to the Office of the Inspector General, DHHS, by hundreds of millions of Medicare dollars annually. One of the few marketing advantages conferred upon ambulatory surgical centers is the ability to provide "no cost" surgery, since 100 percent of the facility payment is paid by Medicare, and 100 percent of the physician's professional services are likewise paid by Medicare if the physician accepts assignment. On the other hand, hospital outpatient departments, which are paid hundreds of dollar more for each cataract case, are required to bill the patient a 20 percent coinsurance amount.

If the President's proposals respecting the imposition of the 20% coinsurance requirement for ASCs' facility costs are enacted, this advantage of providing care in ambulatory surgical centers would be eliminated. As a result, there would be little incentive for beneficiaries to have their surgery performed in Medicare-certified ambulatory surgical centers, rather than higher-cost hospital outpatient departments.

The proposal is also unfair because, as a practical matter, coinsurance amounts are often not collectible because of the limited resources available to fixed-income Medicare beneficiaries. By virtually all accounts, ASC rates do not cover the costs incurred by facilities in providing these services. The rates have not been adjusted since the advent of the ASC program four years ago, despite repeated promises by HCFA to do so. Until such time as ASC facility payment rates are brought into line with the actual costs incurred in providing such services, it is irrational and inequitable to impose coinsurance requirements on the facility reimbursement rates which are a fraction of the amounts paid to the hospital outpatient departments.

Thank you for providing us with an opportunity to present our views on S.2363 and the Administration's FY 1987 budget. If we can provide you with any further information or assistance in your deliberations, please let us know.

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